Tenancy Management in Assisted Living Settings in Vancouver Island Health Authority

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Abstract

Assisted living (AL) is a complex housing program for seniors and other eligible clients that incorporates the notion of choice, autonomy and independence in its service delivery. The AL industry involves a variety of stakeholders from different agencies and organizations; AL is regulated under the *Community Care and Assisted Living Act.*

While popular and appealing to the public, AL suffers from the lack of standardization in its operational and managerial processes. Clients may be vulnerable because of an absence of a dispute resolution mechanism or a support system for AL stakeholders, particularly once evictions arise. Since the cost, time, and effort required to re-house clients when they lose housing is far greater than measures geared towards assisting them in maintaining housing (Shern, et al., 1997), the need for developing the process to ensure eviction prevention in AL laid the grounds for this document.

In the context of research, work-related experience and published literature on AL, I have (a) developed a process for tenancy management, (b) articulated the roles of AL stakeholders in the process of tenancy management and (c) proposed suggestions to improve practice and operations in the AL environment.

Executive Summary

In British Columbia assisted living (AL) is a complex housing program for the eligible clients who need supports in the community to remain independent. Its development followed the example of the American concept for supportive housing in an attempt to fill the gap between the growing need and the lack of availability of the residential care resources for the elderly. Based on the principles of autonomy, privacy, personalization and family involvement, AL proposed a new way of delivering care to the elderly in the community, while providing the security of stable housing and built-in supports. Though met with public approval, the operations of the AL program have still not been fully finalized, and though amendments have been considered for the Residential Care Act, the implementation of these amendments remains on hold.

While the BC government considered regulation of AL through *the Community Care and Assisted Living Act*, AL continued to develop as a housing industry that lacked standardization in its operation and management, producing a vast variation among the sites that claimed to offer AL services. After acceptance of *the Community Care and Assisted Living Act*, the AL industry became more regulated and AL sites are now registered with the Office of the AL Registrar, ensuring the enforcement of the health and safety standards in AL sites. The Registrar is not involved with any dispute resolution of tenancy issues at AL sites. However, the Residential Tenancy Branch will have such authority once the province implements *the Residential Care Act* amendments to govern tenancy conflicts in AL and supportive housing.

As the AL housing continues to develop, the issue of tenant rights and a process for tenancy management has not, due to the variation in AL sites. Specifically, no single

setting followed the same process for transitioning the clients in and out. Regardless of *the Community Care and Assisted Living Act* regulation, the diversity among the practices and services offered in AL sites remains unchanged.

Present structure of AL in BC includes a variety of stakeholders that represent different government, public and private organizations. While BC Housing is responsible for subsidizing shelter under the AL program, Health Authorities are entrusted with the client care and with regulating the access and flow for AL sites. AL sites are managed by the for-profit or non-profit organizations that contract the housing space out to the subsidized clients and provide the AL services, in accordance with *the Community Care and Assisted Living Act*. The client population in South Island is constituted mostly of frail elderly and some hard-to-house clientele. While differing by their characteristics and associated issues, these two groups are similar in their desire to be independent in a supportive and stable environment.

Although, in general, the AL program functioned well due to the integrity and professionalism of the involved stakeholders, tenancy management issues were becoming more prevalent causing some clients to lose their housing. The clients' vulnerability to eviction, the absence of a conflict resolution process, and timely involvement of the AL case managers to assist with the clients' care indicated the pressing need for full development of the tenancy management guidelines. Such a need was supported further in the research literature, by the fact that the cost, time, and effort required to re-house clients when they lose housing are far greater than measures geared towards assisting them in maintaining housing (Shern, et al., 1997). As a result, the tenancy management guidelines were developed as part of this paper based on my work related experience and

by reviewing the processes, policies and available AL documentation and research on the operation of AL in BC.

Once the first draft of the guidelines was developed, Penny MacCourt's *Seniors' Mental Health Policy Lens (SMHPL)* was used to identify any negative impacts on the population and to consider all the determinants affecting individual health and well being. The SMHPL was chosen as a framework for the guidelines, because it represents the best practices for fostering social environments and health services that are supportive of older adults' mental health. The guidelines are meant to be a starting point for the dialogue among stakeholders to help determine a time frame for the proposed steps and to incorporate any other feedback on the gaps identified by the SMHPL. According to the analysis, weaknesses of the system include: (a) a lack of the needed resources to support the client, (b) a client's expected willingness to partner and cooperate, and (c) the need for support from all stakeholders and involved professionals to make eviction prevention a reality. Current conditions may make this goal unachievable but can be offset by further improvement of the proposed process.

Some global recommendations for the support of the tenancy management process in AL include suggestions (a) to improve communication among the stakeholders and, thus, transparency in service, (b) to practice with a holistic view of the client and seamless service delivery, and (c) to foster a culture of support among the organizations, the stakeholders and tenants. Eviction prevention concerns a variety of organizations and services; only by working together will success become a reality.

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Glossary of Terms

Assisted Living (AL) A housing arrangement that must contain all of the following elements: a private housing unit with a lockable door, hospitality services, and personal care services. An AL unit is any unit where the health authority enters into a contract with a service provider to jointly provide the three elements of AL AND where the health authority controls who moves in and out of the setting (Interior Health, 2004)

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AL Operator/ landlord (referred to as Operator) An individual (e.g. company, corporation, non-profit society, etc.) who owns or has full authority to operate a residence in accordance with the Vancouver Island Health Authority contract. Operators and/or their staff provide tenants with meals and hospitality services. They also (when contracted to do so) supervise or assist tenants with personal care, taking medications, and accessing social and recreational activities as outlined in the Care and Service Plan. The Standards, which apply to the Operator, also apply to staff hired by the Operator (Interior Health, 2004).

AL case manager An employee of the Vancouver Island Health Authority Health Home and Community Care Program who is

responsible as a case manager for Assisted Living occupants and acts as the primary point of contact between the Assisted Living Operator and the Vancouver Island Health Authority on the provision of services (Interior Health, 2004).

Campus of Care co-location of independent housing, AL and residential care at the same site (VIHA, 2008)

Care worker Unlicensed nursing staff who are trained to attend to the immediate physical needs of the client. Care workers are not allowed to make any independent decisions regarding the client's care and are mandated to report any changes to the care agency's head office where the supervisor directs their further actions.

Case Management A collaborative process (with the tenant, family, Assisted Living Operator, and Community Care Case Manager, involving the arrangement and coordination of formal and informal health services across the system. Case Management generally includes: screening, assessing, planning, arranging, coordinating and providing specific services; determining consistent allocation of services; and

monitoring and reassessing as part of the quality of care and improvement processes. The monitoring involves the aspects of housing, hospitality, and care provision for occupants in assisted living sites as per contract agreements. Case Management is a professional service. It is a process incorporating the balancing of occupant advocacy with effective and efficient utilization of resources (Interior Health, 2004).

Community Care and Assisted Living Act The only piece of provincial legislation that regulates the AL industry in BC. It specifies the conditions under which the clients are eligible to access and stay in AL. It also articulates the governance of AL, its services, the registrant's responsibilities and the role of the Office of the AL Registrar.

Hospitality services The bundle of client services that provide meals, housekeeping, laundry, opportunities to socialize through recreational activities, and a 24-hour emergency response system in AL settings.

Occupancy Agreement (Tenancy Agreement) An agreement that defines the expectations, rights (or obligations of the occupant and the assisted living service

provider), including the services to be provided, the charge to the occupant for those services and the conditions under which an occupant will be required to move out of assisted living (Interior Health, 2004).

(AL) Tenant/ client/resident — Used interchangeably to refer to the eligible individual who resides in an Assisted Living Residence and requires professional services, supervision and assistance with personal care and social and recreational support. This individual is no longer able to remain in his or her own home and has been assessed as requiring a more supportive environment. At the time of referral, the tenant may reside in the community, a hospital, or in a care center. The tenant chooses to live in an Assisted Living Residence and care and service needs can safely be met in an Assisted Living Residence (Interior Health, 2004).

Residential care/ long term care/ complex care — Used interchangeably and refer to a facility care environment that provides 24 hour a day nursing services and continuing medical supervision. It is designed to support the person with a severe chronic disability that impairs cognitive and/or physical skills and leads to a consequent functional deficit that requires 24 hour a day

professional care and supervision outside of the resources of acute care hospital (Ministry of Health, 2007).

***Residential Tenancy Act* (RTA)** Provincial legislation which regulates rental property, landlords and tenants. It offers basic protection for renters regarding matters that fundamentally affect affordability and one's sense of security in his/her environment (Spencer, 2004b). It balances the interests of landlords, who own the property, and the tenants, who are paying to use it. It addresses such issues as security of tenure, security of damage deposits and their return at the end of the tenancy, basis for evictions, who is responsible for regular "wear and tear" of the property and so on.

(AL) Site/setting The housing that is registered under the *Community Care and Assisted Living Act* and offers AL services to the eligible clients.

(AL) Stakeholder refers to the key players in the AL industry and includes (a) the regional health authority - AL office and home and community personnel, (b) the for- profit or non-profit organization that runs the AL housing, (c) the home care agency and its care workers, (d) BC housing, (e) the

resident, and (f) the Office of the AL Registrar (VIHA, 2007b).

Unscheduled personal care Personal care that cannot be scheduled for specific time periods (e.g. assistance with transfers, assistance with toileting). If an AL client's needs cannot be met by the scheduled task, then it is time for the AL client to move to a higher care level facility, complex care, where the level of supervision and assistance is offered on a 24-hour unscheduled or as-needed basis.

Introduction

In the era of health care budget restraints and increasing need for more community resources, innovations in resource management are met with enthusiasm. Assisted living (AL) is one of such innovations, designed to prevent premature institutionalization and support the clients longer in the community. AL promotes individual independence and fosters a supportive environment that is built around the client's needs and interests by offering stable housing and built-in support to eligible clients. AL offers flexibility that residential care can never provide and, as a result, has gained popularity as a care option among elderly who are seeking more choice and flexibility in their housing arrangements.

While promoted by the government as affordable housing, the AL industry faces its own challenges with incomplete provincial regulations and a lack of legal guidelines for tenancy dispute. In its present structure, AL does not offer any legal protection to tenants in terms of tenancy conflict and mediation, thus placing tenants into vulnerable positions if there is a need for relocation. Evictions have become a method of ridding the housing of the unwanted individuals, potentially displacing them into environments that are less supportive and flexible than AL (Acacia Consulting and Research, 2006). While the client bears the responsibility of asocial behaviour and resistance to the house rules, the lack of a tenancy management process in AL deprives the client of the opportunity to get the required supports to retain the stable housing AL offers. Because of this gap, the eviction process may be seen as a failure of AL and the rest of the involved stakeholders to support the clients who are vulnerable due to their lack of skills in retaining communal

housing independently. This fails to address the needs of the population that AL was meant to target.

Research indicates that evictions and the distress associated with the process do not just disrupt the individual lives of the AL clientele, but also place a heavy burden on the system (Shern et al., 1997; Slade, Scott, Truman, & Leese, 1999; Slatter & Baulderstone, 2003). The cost of time and effort to re-house the clients is greater than eviction prevention efforts, that may not just ensure the client retains the housing but also provide the clients with the ongoing support they may need to function independently (Acacia Consulting and Research, 2005). The proposed tenancy management process in AL is designed to improve communication among the stakeholders, augmenting their collaborative relationships and shifting the focus to the client's needs, thus fulfilling the obligation to the client to offer appropriate care and support within the communal settings.

In the context of AL improving its services and operation, one point is clear: eviction prevention is an issue that concerns many organizations and agencies, and only by working together and communicating effectively will success become a reality.

Chapter 1: Assisted Living and Its Regulation

1.1 Assisted Living and the Context for Its Development in the USA and Canada

Assisted living (AL) is a common term related to housing and care options for the elderly and people with disabilities. While the term definition varies, depending on the source of the research and the context, its features generally include senior housing with hospitality services, assistance with personal care, opportunities for socialization, and around-the-clock emergency response. AL was developed by industry to fit consumer demand, and as a result, there is a lack of uniformity among the various settings. Within the same geographical location, senior housing settings claiming to be AL can vary in the services they deliver, the population they serve and the regulations by which they function (Kissam,Gifford, Mor, & Patry, 2003). This disparity increases among the provinces and states, affecting the portability of research evaluating the effectiveness of AL on the health of a particular population. A lack of clarity in AL terminology and an absence of consistency in their operations impedes policy makers in their work toward equitable service provision, practitioners in their provision of quality care, and consumers in their exercising of informed choice in selecting care options for their needs (Zimmerman & Sloan, 2007). The absence of uniformity of terminology in available research literature also makes it difficult to analyse results and discover common themes. The ambiguity is present in both Canadian and American literature, though American research is more abundant, likely due to its longer history of AL.

1.1.1 Assisted living in the United States of America (USA).

In the USA, AL evolved in the late 1980's as a new and progressive approach to the needs of individuals with limited abilities (Golant, 2001). It was meant to support individuals with physical and cognitive limitations by providing a continuum of care services for individuals who are not able to remain in the community safely, but do not require the constant care of the nursing home. AL's environment is designed to have residential qualities in both character and appearance, with the emphasis on home-like appeal and an abandonment of the design elements seen in traditional institutional care settings (Regnier & Scott, 2001). In the typical AL setting, the supportive services for activities of daily living (ADLs) and instrumental activities of daily living (IADLs) are available 24 hours per day and are delivered in a way that promotes the dignity and independence of each resident, while involving the resident's family, neighbours and friends (Regnier, 2002). The philosophical stance of AL has led some researchers to conclude that AL was not "just another addition to the already expansive continuum of long term services", but "a philosophy of how care and services ought to be delivered" (Utz, 2003, p.380).

The AL philosophy is based on the notions of autonomy, privacy, personalization, family involvement into care, and socialization (Kapp & Wilson, 1999; Regnier, Hamilton &Yatabe, 1991). These are the universal philosophical tenets that provide a common ground for the variety of AL settings and continue to provide the guiding values in both Canada and the USA. Some of the AL settings also promise aging in place, offering to individualize the supportive services as the client's needs start to change with the aging process. Since the term, assisted living, is loosely adopted by a variety of USA

senior housing settings (Campus of Care, retirement communities, congregate style housing, etc.), the true notion of aging in place may become possible, with a certain price tag attached to reflect the increasing needs of the residents (Kissam, Gifford, Mor, & Patry, 2003). Depending on the state, some AL residences are actually licensed as residential care. However, according to a 2003 national survey of AL sites in the USA, AL sites differ widely in ownership, size, policies and degrees to which they manifest the AL philosophy, likely due to the lack of consistent regulation (Hawes, Phillips, Rose, Holan & Sherman, 2003; Kane, Chan & Kane, 2007).

1.1.2 Assisted living in British Columbia, Canada.

In British Columbia (BC), AL emerged as an alternative housing and care option for the elderly in the late 1990s. Its appearance reflected consumer need (Gnaedinger, 1999) and a favourable market niche, in light of policy changes in the eligibility criteria for subsidized residential care and support services in the community. As the eligibility became more rigid and excluded those elderly who required light supportive services, the need for more options dictated the development of private housing with a care component to meet the demand (Araki, 2004). The provincial government recognized this need in 2002, when as a part of election campaign, the BC Liberals announced a commitment to provide 5,000 new intermediate (AL) and long term (residential) care spaces by 2006 (Spencer, 2004a). Christened as a “New Era”, the delivery of AL housing and care to frail seniors was supported with the passage of Bill 73, the *Community Care and Assisted Living Act*. This Act was meant to regulate the private and public assisted living settings, promote their expansion via new construction or renovation of existing care facilities, and ensure that AL would become a growth industry in BC (Canada Mortgage and Housing

Corporation, 2003). Unfortunately, the lack of clarity in how core concepts and policy goals were to be operationalized, allowed for further diversification of the AL settings and, in some respect, presented similar issues to that of the American AL experience.

Similar to the USA, the development of AL in BC reflected the gap in housing and care services for the elderly. Official government press releases quoted elderly persons as wanting more choice and options that promoted independence and quality of life (BC Ministry of Health, 2002; Gutman, 2003). In their review of supportive housing, the BC Ministry of Health (1999) commented on the need to have transitional housing for the population whose needs fell between the clients residing in the community and the clients residing in nursing homes or residential care. AL seemed to fit the need perfectly (Crawford, 2003) as, according to *the Community Care and Assisted Living Act*, it was conceived as a social model of housing that increased choice, provided the possibility of aging in place and reduced the demand for publically funded complex care placement (Araki, 2004). Moreover, the AL social philosophy was appealing to the clientele as it focused on a home like environment (private, self contained apartments with an individual bathroom and kitchen) and accented choice, autonomy and privacy. The AL environment fostered the residents' involvement into planning their own care while allowing them to contribute to their social environment. The residents exercised their own choice with regard to taking part in the activities, how often they wanted to have meals in the common dining room, with whom they preferred to sit, and so on. The absence of a mandatory routine and the relative flexibility of scheduled care supported the residents' autonomy and personal preferences. AL quickly attracted popularity as it was different from the traditional residential care but still offered the needed supports.

Though the main target population of AL was seniors with a light care load (previously known as intermediate care clients), in the southern end of Vancouver Island, AL also offered housing and support to a younger population with addiction and mental health issues. The *Community Care and Assisted Living Act (2002)* is the only piece of legislation that regulates the AL industry in BC. Its Section 26(3) clearly states the requirement of the AL clientele to be able to direct their care, or initiate a complaint. As the AL settings are registered rather than licensed, AL regulation is complaint driven and therefore requires the residents to have an ability to articulate their opinions and preferences around their housing and the care they receive. The only time when an AL setting is able to accommodate a cognitively impaired resident is if the client is accompanied by a spouse who is responsible for 24 hour supervision of the impaired resident and will make the decisions on his/her behalf. Another exception is listed under Section 37 of the *Mental Health Act* when the resident is required (under the terms of the Mental Health Act) to live in AL instead of the mental health facility, as long as the resident is able to make decisions around ADLs (Community Care and Assisted Living Act, 2002).

While somewhat similar to the American prototype, Canadian AL has distinct differences in several criteria: (a) narrower criteria for admission, (b) lower percentage of facilities that can accommodate persons with dementia, (c) lower staff-resident ratios, (d) fewer unscheduled personal care and health services, and (e) more reliance on the split model where operators provide personal care services by subcontracting with outside agencies (Golant, 2001). In BC, besides not being able to house clients with dementia as per the *Community Care and Assisted Living Act*, AL is supposed to have scheduled

supportive services, rather than the American standard of being delivered on an as needed basis. Moreover, in BC the need for unscheduled assistance serves as exiting criteria for AL residents and is indicative of the client requiring a higher level of care than what AL can offer. The presence of strict exiting criteria also suggests that AL in BC cannot accommodate seniors' aging in place, contrary to what some of the marketing AL literature claims to offer. The *Community Care and Assisted Living Act* regulations and exit criteria for AL decreased the demand for publicly funded complex care placement and thus caused the initial attempt to promote the possibility of aging in place to fail. The most common destination for AL clients who are moving out is residential care. The non-official statistic for the average length of stay in AL on the South Island is 15 months (M. Blandford, personal communication, April 10, 2008), considerably less than the average of 28 months in the US (Gutman, 2003). This does not come close to providing the conditions of aging in place. AL became a transitional step before residential care and the need for the residential beds still remains high, though somewhat diminished by AL housing. For the purpose of this paper the term AL will reflect the definition in the *Community Care and Assisted Living Act* and refer to the form of senior housing that offers hospitality, prescribed care services, opportunities to socialize in common areas, and is registered with the Office of the AL Registrar of BC.

1.2 Criticism of Assisted Living Model of Housing

While federal funding was allocated to BC under the Canada-British Columbia Affordable Housing Agreement (Spencer, 2004a), personal care services in AL were expected to come from regional health authorities with no increase in the regions' budgets. In order to support the new provincial mandate, health authorities started to

close long term care beds, toughen the eligibility criteria for subsidized complex care and cut down on home support services in the community to free the funds and resources to accommodate the AL model (Araki, 2004; Cohen, 2003; Spencer, 2004a). This "robbing Peter to pay Paul" approach laid the grounds for the ongoing criticism of AL for diverting funds away from complex clients and social housing (Irwin, 2004), eroding the residential care and community supports (Cohen, 2003), and continually struggling to meet the consumer demand for shelter and flexible care options.

The AL model of housing was also criticized for the cost shifting from the provincial government to individuals. The estimated daily cost per resident in AL was half of the daily cost in residential care (Cohen, 2003). The monthly rate in AL for each resident is determined by his/her income and is set at 70% of his/her total earnings. Though the government subsidizes the difference between the resident's income and the value of the shelter and care in the AL setting, that cost does not include BC Hydro, telephone and TV charges, laundry costs, medical supplies, etc. Not only do residents pay the cost for items that would normally be covered by the facility (e.g. supplies for incontinence products, wound care), the resident's income also determines the use of services (e.g. foot care, bathing assistance instead of showering, companionship services) that are needed, but are not offered in the AL package. The notion of choice for personalized services becomes illusionary, as it depends on a combination of the package offered by each individual AL setting and what the resident can afford. The issue of affordability becomes important as the damage deposits, extra service charges etc. make AL unaffordable for seniors in low income brackets. Typically, these people are single,

widowed females that tend to live longer and, as a result, may have more functional disabilities in old age and the need for assistance (Gnadinger, 1999).

Another frequent criticism of the BC government is the attempt to substitute AL for residential care beds (Spencer, 2004a). Though it may be appealing, due to the immediate cost savings, such an approach is flawed from the beginning, as AL reflects the need of a certain population only and is not able to support clients with high care needs. As obvious from the fast overturn, as AL clients become frailer, they start to require unscheduled assistance and, with cognitive deterioration, they become unable to direct their care. As occurred in the USA, AL in BC is unable to solve the problem of bed shortages in residential care, an issue that keeps resurfacing in response to more announcements of new AL construction.

1.3 Assisted Living Service Structure in BC

According to the *Community Care and Assisted Living Act*, AL is defined as a "premises, other than a community care facility, in which housing, hospitality services and at least one but not more than two prescribed services are provided by or through the operator to three or more adults who are not related by blood or marriage to the operator of the premises" (Community Care and Assisted Living Act, SBC 2002, c.75, s.1). Services in AL are divided into housing, hospitality, support and prescribed services.

Housing can be described as "accommodation that ranges from private, lockable rooms to self-contained suites with common dining and recreation spaces" (Karmali, 2006, p. 9). Following this description, AL settings interpret the *Community Care and Assisted Living Act* freely, as there are no specific requirements as to what the settings need to incorporate in their design and environment to ensure the home like atmosphere,

that is so frequently marketed for AL. Presently in the South Island, the AL settings range from a heritage house that accommodates 12 people to a Campus of Care that includes both residential and assisted living buildings with 130 residents (VIHA, 2007a). The sizes of the apartments vary from 150 square feet in the heritage house to 700 square feet with one or two bedrooms in large AL settings. All settings, regardless of size, have common areas for dining and socializing, however the quality of the food and social activities will depend on each specific site.

Hospitality services refer to meals, housekeeping, laundry, opportunities to socialize through recreational activities, and a 24-hour emergency response system. The term, hospitality services, was inherited from high-end American AL projects, where the regular supportive services for core needs are made to sound as luxury (Spencer, 2004a). The AL sites usually hire the workers directly to provide these hospitality functions, although meals are sometimes catered rather than made on-site. Twenty-four hour emergency response varies from having staff on site, to having someone with a 15 minute response time. Emergency response may also include family or a designated individual – though this model is less frequent in newer AL sites. It is, however, more common in rural settings.

Support and prescribed services describe two levels of personalized assistance: either routine, supportive in nature, or prescribed, more intense and offering maximum assistance. These personalized tasks may come from any of six categories: (a) activities of daily living (ADLs), (b) medication administration and monitoring, central storage and distribution of medications, (c) maintenance of cash resources or property, (d) monitoring of food intake and therapeutic diets, (e) structured behavioural programs, and (f)

psychosocial rehabilitation or intensive physical rehabilitation. The operator of the AL site is allowed to offer services in all six categories, if the services are routine in nature and only two of the selected services are at the intense level (Community Care and Assisted Living Regulation, BC reg 217/2004, s.2). The operators usually choose the type of prescribed services, when the setting is registered as an AL site. These prescribed services pertain to the whole AL residence and frequently consist of assistance with ADLs and medications.

As per the AL Registrar's requirement, the operator must develop and maintain personal service plans that accurately reflect the needs, risks and service requests for each resident. The operator is also responsible for ensuring that the service is delivered in a safe manner and environment (Office of the Assisted Living Registrar, 2007). The assessment of a resident's needs and development of the individualized service plan occur at the time of the resident's admission to the AL site. Creating it involves the potential resident, the operator and the AL case manager. The service plan serves as an agreement between the parties regarding their mutual expectations and is used as a staff guideline for service delivery. The service plan is updated on regular basis by the AL case manager, when the resident's needs change and the client requires an adjustment in personal services.

Regardless of the level of services, services are expected to be delivered in a respectful manner, according to the resident's preference, needs and values and in a way that promotes maximum dignity and independence, with involvement of his or her family and friends (Office of the Assisted Living Registrar, 2007). Philosophically, AL residency accentuates choice, autonomy, privacy, personalization, and family

involvement in care and socialization. Borrowed directly from the USA AL model, these qualities accent the social aspects of care and separate AL from the institutional settings. The Registrar frequently refers to the AL values in her expectations of the operators' management of the AL settings. These values also must be emphasized in the AL tenancy agreements with potential residents.

Though the AL Registrar has clear expectations of the operator's role, there is a limited amount of guidance on the mode of service delivery. The most common model for personal service delivery in the South Island involves contracting home care support from a home care agency with the assistance of the health authority. This model brings more players into the communication loop, as care workers are not allowed to report directly to the operator regarding changes in the status of residents. Some of the communication happens unofficially, however a frequent complaint of care workers is the lag time in getting needed changes incorporated into personal care plans. It takes time for the message to be communicated to the main office of the care agency and then forwarded to the AL case manager to address. The complexity of staffing and reporting processes sometimes interferes with the timely communication of issues and has the potential to impair the quality of service delivery to the client.

1.4 Stakeholders and Their Roles

The AL framework, and its intricacies, includes a variety of partners, making the collaborative relationship complex. While the role of each stakeholder includes a definite set of responsibilities, mutual relationships continually evolve in response to balancing the regulations both within the organizations and province-wide. The AL model is a complex mix of housing, health care and other services. Due to a variety of legislative

interpretations by the regional health authorities, the AL model differs in each health authority and, thus, may involve or exclude various stakeholders in different ways. The role of each stakeholder is defined locally and may not be comparable to other health regions.

One strong similarity in BC health regions is the involvement of two Ministries, the Ministry of Health for health and safety in AL, and the Ministry of Housing, for funding affordable shelter and any tenure or service protection issues (Spencer, 2004a). This governing structure leads to a separation of mandates, funding and the development of processes for AL. The resulting complex patchwork approach is characterized by broken or difficult communication and barriers to adopting and implementing any changes in the AL processes. Furthermore, the efficiency around AL development is inhibited, and the framework appears user unfriendly, both for clientele and the stakeholders. Moreover, inconsistent terminology complicates communication. Terms like *supportive living, supportive housing, independent living* and *assisted living* are used interchangeably by the Ministries, though the meaning of the terms is not consistent, sometimes changing on monthly basis (Spencer, 2004a).

For the purpose of this paper, the focus will be on Vancouver Island Health Authority (VIHA), South Island. In VIHA the main stakeholders in AL include: (a) the regional health authority, i.e., the AL office and home and community personnel, (b) the for- profit or non-profit organization that runs the AL housing site, (c) the home care agency and its care workers, (d) BC housing, (e) the resident, and (f) the Office of the AL Registrar (VIHA, 2007b).

1.4.1 Regional health authority (VIHA).

In AL, the regional health authority plays a large role: screening and transferring the residents into AL, supporting them while they reside in AL, and transferring them out once they do not fit the eligibility profile any longer. With respect to AL, the health authority's responsibilities can be divided into two parts: management of AL as a program, and the provisioning of regular supportive services to the AL client. There is a separate structure for each responsibility: an AL department for any issues surrounding AL, and Home and Community Care structures for the professional support and assessment of clients within AL.

The main function of the AL department in VIHA is to be a central resource for VIHA staff and other stakeholders on issues related to AL. The AL department (a) develops and manages contracts between VIHA and the operators; (b) performs annual site reviews for quality management; (c) liaises with BC Housing, the Ministry of Health, and the Office of the Assisted Living Registrar regarding regulations, site development and operations; (d) develops practice guidelines for AL case management; (e) supports and maintains the operator network; and (f) provides a registered dietician to approve meal plans and delivery at the AL sites (VIHA, 2007b). The AL department is a specialized support structure for the AL Case Managers. It ensures the smooth operation of AL as a health region wide program and its further development.

The Home and Community Care department of VIHA delivers community-based health care services for eligible clients who reside in AL. It is staffed by a variety of professionals: home care nurses, dieticians, rehabilitation therapists, social workers and case managers. The case managers facilitate the transition of clients into AL and offer

ongoing support. Access to the rest of the home and community team is provided via referrals from the case managers. The manager of Home and Community Care is responsible for operational oversight of service delivery to VIHA clients in the community, including those in AL.

The relationship between these two departments is very close, especially when transitioning clients. The AL eligibility criteria are observed by the geographical case manager during regular assessment visits in the community. In order to qualify for AL the client must require accessible housing, personal assistance with ADLs, hospitality support and social opportunities (Office of the Assisted Living Registrar, 2007). The client must be able to direct his/her own care and initiate a complaint if needed (Community Care and Assisted Living Act, SBC 2002, c.75, s.26.3). The absence of a standardized cognitive assessment tool for AL in VIHA makes the preliminary screening for cognitive impairment difficult, especially when the client only exhibits limitations with insight and certain ADLs. If the client fits the AL criteria and indicates interest in relocating to AL, the geographical case manager completes the paperwork to place the client on the preferred AL waiting list. The client is free to select as many AL sites as he/she likes. Regardless of the preferences, the wait to access AL for those living in the community at present is often between 1 to 2 years.

Once the client's name reaches the top of the list for the preferred site, the AL case manager reviews the client's paperwork for the specified AL setting. However, after a long wait the client may no longer fit the environment of that particular setting due to a variety of reasons: (a) increased frailty and cognitive impairment, (b) lack of interest and change in the personal circumstances, or (c) medical needs that are too complex for the

setting at that time, etc. The AL case manager liaises with the geographical case manager to address any concerns and, once those are satisfied, schedules a tour of the setting with the client, the family, and the operator, who has the right to know any information about the potential resident that may affect the health and safety of the rest of the residents (Office of the Assisted Living Registrar, 2007). The operator has the final say regarding accepting the client (VIHA, 2007c). When all parties are satisfied, the client moves into the AL setting.

The AL case manager in conjunction with the client maintains the individualized care plan and serves as a bridge between the client and community resources, guiding, advising and helping the client to connect with other health care professionals and community resources. The AL case manager also serves as a liaison between the involved stakeholders, supporting the ongoing communication and advocating for the client and the family. Given their knowledge of AL legislation and of the services available in different AL settings, AL case managers often are able to recommend different options if the client's preferred site does not appear to be a good match for his/her specific needs.

Clients who develop cognitive deterioration or require ongoing unscheduled assistance (e.g. with transfers, toileting etc.), are reassessed by the AL case manager for residential care. Until such a bed becomes available, the AL case manager adjusts the AL supports to accommodate the client (VIHA, 2007c). The AL case manager mediates discussion among client, family and health care providers regarding changes in the client's care level and the need for a more supportive environment. A medical review of the client's status may also be requested at that time. Once the residential care bed

becomes available and is accepted by the family, the resident is transferred out of AL and the family has one month to give notice and to clear the apartment of the furniture.

The complexity of the client transitions in and out of AL rests on (a) the complicated relationship among the stakeholders and (b) the individual circumstances of each client. Although VIHA has primary responsibility for allocating and controlling the health resources on Vancouver Island, the various departments within VIHA have different processes for accessing the resources and communicating. Thus, one client can have a variety of professionals involved with his/her care on his/her health continuum. These professionals may not necessarily communicate with each other or may even be unaware of each other's involvement, especially if several departments are engaged (e.g. Mental Health, Seniors Health, Home and Community Care). The task of maintaining effective communication becomes even more complex when outside stakeholders become involved. This is obvious in AL where everybody has a definite role and certain steps have to be completed before the next step can be made (e.g. the family has to agree to move the furniture on time; the operator has to clean the suite; the AL case manager has to screen the next potential AL candidate and organize a tour). Communication skills become the main asset in the work of AL case managers.

1.4.2 For-profit and non-profit organizations.

The next AL stakeholders are the organizations that build, own and maintain the AL settings. These may be non-profit charitable organizations (e.g. the Victoria Cool Aid Society, Baptist Housing), or independently run senior housing businesses. Regardless of their for-profit or non-profit status, they must register with the Office of the Assisted Living Registrar to hold a contract with VIHA. Once registered, the AL site falls under

the regulations of the *Community Care and Assisted Living Act* and, therefore, has to meet ongoing requirements to maintain the registration. The operator's responsibilities include managing the building, delivering the hospitality services, maintaining appropriate staffing to deliver the services in a safe and healthy manner, approving tenants, managing occupancy agreements, ensuring the quality of care and services, tenant dispute resolution, and abuse prevention (Office of the Assisted Living Registrar, 2007; VIHA, 2007b).

The operator, in constant contact with the AL case manager, is responsible for keeping a "watchful eye" over the residents, while not intruding unnecessarily into their private lives and personal decision making. By embracing the AL philosophy, the operator follows the key principles of AL: choice, privacy, independence, individuality, dignity and respect, while supporting the notion that, regardless of the need for support and assistance in daily life, the residents retain the ability and right to manage their own lives (Office of the Assisted Living Registrar, 2007).

In essence, the AL philosophy is what distinguishes AL from a nursing home, presenting an ongoing issue of balancing between assisting the residents and doing things for them. In reality, AL is set up to do as little as possible for the clients, but as much as needed to maintain their independence (Utz, 2003). Some clients expect more care than is mandated and interpret the care workers' minimalist approach as the way to avoid doing their job.

This delicate balance can present dilemmas for the operator. One issue is allowing personal autonomy versus the safety and security of the rest of residents. It is noted that the safer the environment, the more difficult and more expensive it is to make it feel

"home like" (Kapp & Wilson, 1999). For example, many residents smoke in their quarters, regardless of the non smoking regulation, exposing other residents and AL staff to harmful second hand smoke. Unless the operator and resident find a common solution, the client may receive an eviction notice. Preserving client's privacy also poses problems when the operator believes resident's health is at risk. An example is the client who does not come for meals or responds to phone calls or calls at the door. At some but not all Al sites the tenancy agreement specifies conditions under which the operator may enter the suite. This mixed role of being a landlord and "a watchful eye" for the well being and safety of the residents is tricky for the operator as the personal care component is contracted out to a home care agency. Care workers do not report to the operator, but the operator is responsible for the quality of the care under the *Community Care and Assisted Living Act* (Office of the Assisted Living Registrar, 2007). At the same time other support staff (cleaners, cooks, receptionists, first responders) are under the direct supervision of the operator.

The operator's responsibility for the safety and quality of care is also challenged by the fact that there are no guidelines for residency in AL. Although the legislature passed the *Residency Amendment Act* for AL and supportive living in 2006, it has not been enacted and the Residential Tenancy Branch has no jurisdiction over AL, leaving the tenant vulnerable (Spencer, 2004b). The Office of the AL Registrar is the only AL regulating body; however it covers health and safety issues only, excluding all tenancy issues. In addition, there are no mandatory or standardized training programs for AL providers, thus operators rely on their professional background, such as nursing home management, the hospitality industry or property development, to name a few. This may

influence the extent to which the AL philosophy is implemented, as the appropriate staffing levels and training, flexibility of care, the availability of residents' choices, and overall commitment to the resident's wellbeing rest completely upon the operator's management decisions (Karamli, 2006). According to Golant (2001), the only difference between for-profit and non-profit organizations may be the quality of the facility management practices. In recognition of that, the VIHA AL department assured responsibility for developing and supporting the network of AL operators. As it is in the early stages of development, the impact of this initiative remains to be seen.

1.4.3 Home care agency and care workers.

In the South Island, VIHA contracts the personal care services to another stakeholder, a home care agency. The home care agency is responsible for performing the scheduled tasks of the client's care as directed by the AL case manager (VIHA, 2007b) and for providing oversight, training and direction to the care workers on medical issues. The agency supervisors communicate changes in client status to the AL case manager, who reviews the client and adjusts the care plan. Proactive clients may phone the AL case manager directly to advocate for their own interests. The care workers are not allowed to contact the AL case manager, the operator, or the client's family directly; all communication is funnelled through the care agency's head office, with resulting delays. Sometimes, depending on their relationship with the operator, care workers go directly to the operator to expedite the process, but this process is not sanctioned.

As there is no specification regarding the model of service delivery for AL, outsourcing for personal care is quite common throughout BC. These care workers are unlicensed staff, who are overseen by a nursing professional remotely. The care agency

nurse instructs the care workers, delegates the nursing functions (e.g. medication administration) and ensures their proper administration. Too often, due to staff shortages delegation and training take place over the phone. This increases the risk for miscommunication, especially for those workers whose second language is English. This is an ongoing quality assurance issue in personal care service in AL.

1.4.4 BC Housing.

The main role of BC Housing is to provide a shelter subsidy under the Affordable Housing program to the VIHA funded AL sites (VIHA, 2007b). Several concurrent models of funding exist between BC Housing and VIHA. In some of the AL sites BC Housing subsidizes only the shelter portion of the expenses. In the newest AL projects, BC Housing also funds hospitality services and meals. For operations, BC Housing supports AL in the financial sense only, paying the AL operator a specified amount for each VIHA funded suite (M. Blandford, personal communication, April 10, 2008). All communication between BC Housing and the AL department of VIHA occurs at higher managerial levels, intensifying when new LA sites are being developed and built. BC Housing does not deal with the daily day-to-day issues in AL; leaving those responsibilities to VIHA and the operators.

1.4.5 Assisted living client.

As mentioned earlier, there are strict criteria for admission into AL. The majority of AL settings cater to adults who are 65 years of age or older, while some will admit clients at 55 years of age. The client is seen as a partner in care and AL is his/her home. The main responsibilities of clients in AL are: (a) to assume and retain maximum

personal responsibility for their own health and well-being, and maximum involvement in decision-making; (b) participate in decisions about their own care (Ministry of Health, 2007), (c) remain engaged in the community, (d) contribute to the socialization in AL, follow the rules and regulations in AL legislation, as well as (f) file taxes annually so that the AL rate can be adjusted as per income (VIHA, 2007b). A few of the AL settings have a residential council of residents who decide on the social activities, fundraisers, environmental improvement and so on.

The client is treated as an individual with the right to live at risk and make his/her own informed choices. However, the client's competency is questioned if the choices are consistently poor or subject the rest of AL population to undue risk. The registrant book for AL operators contains some guidelines to determine when to contact the AL case manager for a reassessment of the client (Office of the Assisted Living Registrar, 2007).

1.4.6 The role of the Office of the AL Registrar.

Since September 2004, all public and private AL sites are required, by law, to be registered with the Office of the AL Registrar. The main functions of registration are to (a) legally distinguish the AL from other forms of residential housing and care options, (b) to establish the boundaries of care within which the operator can decide on the population and prescribed services, and (c) to initiate the process by which the operator becomes obliged to abide by provincial legislation (Office of the Assisted Living Registrar, 2007). Via this registration, the AL Registrar is able to review (a) the proposed general operation of the facility, (b) its 24 hour emergency plan, (c) type and methods of service delivery, (d) design and accessibility considerations, and (e) the operator's suitability and experience to run the AL setting (Spencer, 2004b). The Registrar's main

consideration is to ensure that the AL setting will provide the services "in a manner that does not jeopardize health and safety of the residents" (Community Care and Assisted Living Act, SBC 2002, c.75, s. 25.1). To accomplish this, the Registrar organizes a site visit by a two person team (Office of the Assisted Living Registrar, 2007). Once the site is registered, the regional health authority AL office performs annual reviews with all stakeholders present. The clients' input is collected via a questionnaire prior to the review. The purpose of the annual review is to ensure that the AL site follows the AL management regulations and delivers service within appropriate guidelines, as per the contract.

The Office of the AL Registrar is also responsible for complaint resolution of health and safety issues in AL. Each AL site has publically displayed pamphlets that outline the process for initiating a complaint with the Registrar. Both the operator and the AL case manager educate clients about the complaint resolution process on an as needed basis. Some sites have the process outlined in their resident handbooks. Unfortunately, regardless of the available information, the issue of residents being poorly informed of their rights and the process of complaint resolution persists (Wood & Stephens, 2003).

The AL Registrar has the jurisdiction to address complaints regarding the AL site: e.g. non-compliance with health and safety standards, housing a resident that is unable to make a decision on his/her own behalf, or operating an unregistered AL residence (Office of the Assisted Living Registrar, 2007). Complaints around tenancy or service provision are not under the Registrar's jurisdiction unless the complaint relates directly to residents' health or safety. Clients who report complaints are promised confidentiality. After thorough investigation the Registrar may take such progressive

enforcement action as registration amendments, change in the conditions of the registration, registration suspension or withdrawal, or fines on unregistered AL residences. If the complainant is still unsatisfied with the outcome of the investigation, an appeal can be made to the Office of the Ombudsman (Office of the Assisted Living Registrar, 2007).

The Office of the AL Registrar is the only regulatory body for the AL industry. The tenants are vulnerable without protection under the *Residential Tenancy Act,* or any other structure to address their tenancy complaints. Because AL is primarily housing, with health care or other assistance added, the health authorities are poorly equipped to recognize and address many non-health issues that commonly arise and that can undermine the tenancy (Spencer, 2004b). Yet the operators frequently turn to the health authority for guidance around tenancy issues. The need for tenancy guidelines is great, both for the sake of the residents, as well as the involved stakeholders.

1.5 Examples of Assisted Living Sites in South Island

Next, four active operating AL sites in South Island are discussed to illustrate the variety of AL sites in one geographical location.

St. Francis Manor accepts adults 55 years of age and older. It is based in a 1908 heritage house on the scenic waterfront of downtown Victoria. The house was renovated to include private accessible bathrooms in each room, an outside manual elevator and ramps to the common areas of the building (dining room and living room). The 12 rooms vary in size from 150 square feet to 250 square feet. The house is situated on the small piece of flat property in a residential district. The operators of the house are a couple who own the building and provide the oversight for the care of the residents. They run the

social activities and also assist cooking staff with meals. Three meals are provided, and the residents have access to a small, shared kitchenette. The social activities are described as quiet, with a religious service and music appreciation, and daily walking for the residents who are able. Personal services are delivered by the Beacon Home Care agency. There is a home-maker on sight at night to respond to emergency situations. The site has its own bus for social activities and outings. Since the sight is small, residents with some cognitive impairment receive closer attention, and therefore manage longer in AL than they might at another setting. The downside of this setting is the limitation of the social activities, distance from buses and the difficulty that cognitively intact residents experience in making social connection if there are too many residents who have visual, auditory, or cognitive impairments. In addition, the building is not wheelchair or scooter accessible. Funding for shelter is provided by BC Housing via the Independent Living BC program.

Cridge Senior Center is another AL site. It is a part of the campus of the Cridge Society, a non-profit organization that also operates a children's center, and transitional and low income housing. It is situated on the top of a hill in the Fernwood/Hillside area and is surrounded by accessible walking paths and gardens. The Cridge AL site was built on the grounds of an orphanage, the front of the building kept its heritage appearance and there are a few artefacts throughout the building. The building features wide halls with plug in areas for electric wheelchairs and scooters next to each apartment. The apartment size is 480 square feet with one bedroom, a kitchenette and a walk-in accessible shower. Two meals are served in restaurant fashion. The residents are encouraged to mingle and are not assigned their own spot at the tables. The building has an exercise room, bathing

facilities, a chapel and media room, games room with a pool table, darts, and a Nintendo Wii system for tennis and golf playing. A recreation therapist certified in elderly fitness runs the social program. There is also a bus for outings and trips to the malls. The outside features a barbeque that overlooks the children's playground. Multigenerational interaction and activities are encouraged among the residents. The difficulties with the Cridge are the high damage deposit ($800), mandatory $90 monthly fee for bundled Shaw TV/internet/phone, the inability to accommodate couples due to the small room size, and the physical location (at the top of a hill) that impedes easy access to buses for people with impaired mobility. There are four floors with 77 suites in all. The subsidized suites are interspersed with private suites. The population is 65 years or older. Shelter funding is received from BC housing via the Independent Living BC program, as well as Subsidy Assistance for Elderly Renters, SAFER.

Luther Court is operated by the non-profit, Christian Luther Court Society, and is a part of a Campus of Care. In addition to AL, Luther Court provides complex care, independent (low income) apartments and an adult day program. It is situated in the Cedar Hill area, and despite being on the hill, is in close walking proximity to the shops, pharmacies and buses. It has an enclosed outside patio and garden, a tuck shop, barber shop, common laundry room, office area, and library. The site promotes a sense of community and advocates for the residents to move from independent apartments to AL to residential care (all within Luther Court) as the client's status declines. Clients, after moving to residential care, are accommodated to participate in the common social events and to eat in the dining area, thereby maintaining social connections. This Campus of Care is the only site that can accommodate the spouses with different levels of care under

the same roof. The rooms are around 550 square feet with a full kitchen and accessible shower. Two meals are provided in the common dining room. Personal laundry is done without extra charge. The difficulty with this site is the absence of the accessible plug-in accommodation for the electric wheelchairs and scooters (they have to be stored inside the apartment), as well as the ramp to the living quarters, which clients must have the physical ability to navigate. The population accepted is 65 plus. Funding for shelter is provided by BC Housing via the Independent Living BC program.

Hillside Terrace is an AL site that can accommodate clients with addictions and mental health issues. Run by the non-profit Victoria Cool Aid Society, it is fully subsidized by BC Housing and does not have any private suites. It is situated on Hillside Avenue and is an apartment building without common outside areas. There are 45 one bedroom apartments with a full kitchen and a walk in shower. There are common areas for socializing. The dining room has an outside deck. There is also short term parking outside. Hillside Terrace is tolerant to behaviours associated with addictions and also allows the clients to smoke inside their suites. The population accepted is 19 plus. The issues with this site are the expectation of clients to be tolerant of each other and respectful. It also does not have ground floor office space, which makes monitoring the access to the building difficult.

As obvious from the above examples, AL sites are quite diverse in their set up, physical appearance and the population they target. Though all are registered and follow the regulations in the *Community Care and Assisted Living Act*, there are complexities with standardizing the differences.

In the next chapter, the assisted living population is described.

Chapter 2: The Population of Assisted Living in the South Island and Its Characteristics

On the South Island the main AL population is divided into two groups: elderly and hard-to-house clients. While these two groups differ, the commonality lies in their need to be supported to remain independent. Frail elderly require assistance due to age and underlying chronic conditions, while hard-to-house clients battle addiction and mental health issues and require a structured supportive environment to stay off the streets. Since VIHA does not have official demographics for the AL population, other published resources and personal experience will be utilized to provide a general description for both of these groups.

2.1 Elderly: Population Characteristics and Reasons for Exiting Assisted Living

All but one AL setting (Hillside Terrace), specialize in supporting elderly with different degrees of frailty. The main difference between the sites is the qualifying age (usually either 55 or 65 plus) and the length of time the elderly can remain in the settings. The smaller sites and the Campus of Care tend to house frail elderly longer, which may be due to the compact environment and greater chances for the oversight of the residents. The same trend is observed in the American literature, however, because of different AL regulations, true comparison is difficult (Kane, Chan & Kane, 2007).

The majority of AL residents are women, which is indicative of the national demographic of female longevity. The average age of the residents is around 85 with the oldest resident being 101. All the residents require some kind of assistance with ADLs. As frailty increases, assistance with ADLs increases accordingly, including assistance with medications, dressing, grooming, bathing, breakfast, laundry assistance and being

escorted to meals. The majority of residents require support with at least one ADL task. Though the need for personal care is a criterion for AL eligibility, a few (approximately 1%) of the residents improve on their entrance to AL and cancel any assistance services. Their increased independence may be related to the appropriately equipped internal and external environment, regular nourishment and socializing.

Though AL offers the opportunity for socialization, families play an important role in helping residents to adapt successfully to the new environment (Crawford Mead, Eckert, Zimmerman & Schumacher, 2005). At the initial interview, the resident and the family are informed that AL provides supplemental care and that families are still expected to provide support in terms of planning for groceries, appointments, etc. The lone residents without any familial ties are connected with volunteer or paid companion services to provide the support that AL cannot offer.

The main reason for exiting AL for the elderly is an increase in frailty leading to functional decline and progression of cognitive impairment and associated behaviours, demanding more services and oversight than the settings can offer. This trend is similar to Aud's research (2002), in which AL administrators identified the following indicators for discharge: (a) behaviours associated with dementia, (b) behaviours indicating need for more assistance with ADLs, (c) incontinence, (d) wandering, (e) behaviours that did not meet facility expectations, (f) behaviours that reflected change in the physical condition, and (g) aggressive behaviours. Others relate to the client's capacity for decision making and his/her ability to fit in the communal setting, causing tenancy issues that may include such behaviours as smoking inside the suite, being hostile to staff or other residents, letting friends or family live in the apartment for undefined periods of time, and having

an animal in a no-pet building. In such circumstances, the AL case manager together with the client, the family and the operator negotiate an exiting plan for the client. Under the exit plan the client is assisted to modify the behaviour, if possible, or the care plan is adjusted to support the client until more appropriate accommodation becomes available.

The most common option for alternative housing for elderly clients is residential care. This becomes available when increased frailty or dementia exceeds the ability of AL to care for the client any longer (Phillips, Hawes & Spry, 2000). The wait time for admission into residential care can be 10 months or longer and increased resources are accessed from VIHA to support the client during the waiting period. If the client's condition deteriorates, he or she may be admitted to the hospital. In that case, the placement in residential care may be expedited by VIHA to help free acute care resources.

Discharges to residential care are accomplished according to the First Available Bed Policy, under which residential beds are allocated according to availability, not personal preference (BC Ministry of Health, 2002). The family is expected to accept the first offered residential bed and move the client within 48 hours. Failure to do so jeopardizes the client's eligibility for subsidized residential care and forfeits any extra home support that sustained the client at home in anticipation of the transfer to residential care. This lack of choice by the family exacerbates their stress and anxiety, and regardless of the consequences, they may refuse the bed if the residential care facility does not meet their expectations. In such cases the AL case manager is sometimes not notified, and the client remains in AL despite exceeding his/her eligibility and putting a strain on the available resources.

While one can empathize with the family for their decision and the personal circumstances, the ethics of care management revolve around the balance of the needs of all the residents in AL. When non-eligible clients remain in the AL environment, issues of safe care, increased oversight and sharing of the common resources arise. In addition to increasing cost, the very nature of the setting can be changed by serving a more dependent population. Lack of licensed staff and regulations subject these vulnerable clients to more risk and compromised care. Improved communication among the departments in VIHA would enable the AL case managers and the operators to facilitate a safe and more expedient transition of the non-eligible clients to residential care. The tenancy agreement between the operator and the client should also include the information on the conditions and the process for transitioning the client out to residential care from AL.

The second situation is when the client deliberately chooses to go against the regulations of AL, thus making his/her housing options limited. As the AL does not fall under the *Residential Tenancy Act*, the operator is left to deal with the situations to the best of his/her ability and experience. The operator often first gives a verbal warning and depending on the urgency of the situation, he/she will progress to a written letter and finally eviction. There is no uniform practice in this area and some operators deal with the client on their own, informing the AL case manager about the problem only after the eviction letter is issued. Some operators contact the AL case manager right away and deal with the issue as a team. In terms of the options, the client is offered different supports based on the nature of the issue and housing alternatives if such are available. The resident is educated regarding the consequences of the eviction on his/her tenancy history

and, ideally, the client chooses to move voluntarily as per the eviction time line. As the client is seen as an independent individual in the decision making, the choice regarding further action is left to the client with the open offer for support. If the client chooses to decline the offered options and remain in the AL setting regardless of the eviction notice, the operator may pursue legal avenues to address the situation.

The occurrences of the elderly moving out of AL due to the deliberate disrespect of AL regulations or operator rules are not very frequent. When it happens, the chances are that the client suffers from other concurrent conditions - addictions and/or mental health issues that are not adequately addressed. In such cases, the elderly person's experience with exiting AL is quite similar to the hard-to-house clientele of Hillside Terrace, as described next.

2.2 Hard-to-house Clients: Population Characteristics and Reasons for Exiting Assisted Living

The term *hard-to-house* refers to the population whose multiple diagnoses impede their ability to secure housing because they are deemed problematic by housing providers (Gurstein & Small, 2005). Such problematic descriptors often include particular behaviours (e.g. aggressiveness), visual appearance or lack of social skills that are uncomfortable or offensive to housing providers and other tenants. They often have severe mental illness or disability combined with a substance addiction and a physical disability or illness such as Hepatitis C and HIV/AIDS - the combination that makes these people virtually ineligible for social housing (Gurstein & Small, 2005). The hard-to-house clientele is a challenge for service providers due to the limited support for dealing with their problematic behaviours and, as a result, this population is at risk for

homelessness (Shelter Net BC, 2004). Their qualities are also barriers to accessing proper care, as the presence of one disorder is often an obstacle to successful treatment of the other. Seventy to eighty percent of the homeless population suffer from both substance misuse and debilitating mental illness (Haigh-Gidora, Gotto & Taft, 2004). The public bias towards hard-to-house or "underserved poor" (Wagner, 1997, p.), as well as poor communication and fragmented services make it difficult for them to access care and individualized treatment. Regardless of housing being recognized as a cornerstone of care for homeless persons with drug and alcohol addictions (Kraus, 2001), the cycle of evictions continues as a mean of control by landlords and housing authorities (Sahlin, 1997). The lack of appropriate understanding and support of individuals compounds this cycle of homelessness (Duffin, 2007; Pannell, 2006; Slade, Scott, Truman & Leese, 1999).

On the South Island, the Victoria Cool Aid Society is a non-profit organization that deals with issues of the homeless, hard-to-house and marginalized populations. In their mission they strive to eliminate homelessness by creating community partnerships, advocating for and providing emergency shelter, supportive housing and integrated health care in a non judgemental way (Victoria Cool Aid, 2007). Their vast experience in dealing with marginalized populations placed them in the operator role in running and managing Hillside Terrace, a joint partnership project of BC Housing, VIHA and the Victoria Cool Aid Society for hard-to-house clientele. Hillside Terrace is the only assisted living site in VIHA that specializes in this population.

In Hillside Terrace, 60% of tenants are males, which is the reverse of regular AL settings. The average age of the residents is 55-60 years old and their average length of

stay is 2 years. The main drug of choice among residents is alcohol, with illegal drugs following close behind. About 30% of residents have a mental condition, and 90% have more than one addiction habit (I. Munro, personal communication, April, 10, 2008). Similar to the elderly AL population, hard-to-house clients require assistance with at least one ADL task, but their main area of need is financial management and, unfortunately, that is the service that AL does not offer. Most of the clients either have someone with power of attorney or have the Office of the Public Trustee to manage their finances. The clients without either structure set up run a risk of falling behind in rent, due to their financial mismanagement and life style habits. If that happens, the Victoria Cool Aid Society develops a schedule with the client, to pay off the debt. If this situation reoccurs regularly, the AL case manager organizes an assessment of financial competency and connects the client with either a social worker or the public trustee to assist in managing his/her assets. The issue of financial management is ongoing in Hillside Terrace and is one of the areas that needs a better developed support system to assist the clients to live independently.

In Hillside Terrace, very few of the AL residents end up going to residential care as most either die or move out due to their inability to fit into communal living. The main reason for eviction at Hillside Terrace is disruptive behaviour (e.g. uncontrolled drug use, letting other individuals into their apartment who are aggressive or who are selling drugs, etc.) and the failure of the instituted supports to address its impact on the rest of the residents. Hillside Terrace has the highest rate of evictions on the South Island (average 5 people a year), which can be directly attributed to the nature of its clientele. So far, most

of the clients who are asked to leave are offered other housing options and only one client has been evicted to the streets due to conflict and the client's lack of compliance.

According to Johnson (2004), only two-thirds of the homeless population tend to retain their tenancy. The remaining one-third never settle and self- isolate regardless of the built-in supports. The issue of the clientele not getting along or being intimidated by the behaviours of other residents indicates that this population is not homogenous regardless of their life style. They require a more tailored care approach and a wider variety of housing to address their complex needs (Crane & Warnes, 2003; Slade, Scott, Truman & Leese, 1999). This gap in present housing options is obvious, by the fact that Hillside Terrace is the only option on the South Island for this kind of population. The failure to fit into its structure propels a significant number of clients back to the streets. The difficulty that the clients face in accessing services challenges their advocates as well. The AL case manager and the operator have to be creative in seeking alternative resources and organizing the transition for these unfit clients; their success anchors on the willing participation of the client. Unfortunately, the lack of the resources and complexity in accessing them plagues various AL populations, but is more pronounced in the marginalized groups.

Chapter 3: Issues around Tenancy in Assisted Living

There is a variety of research that describes the connection between stable or affordable housing and health (Slatter & Baulderstone, 2003). According to Dworsky and Piliavin (2000), the stability of the home to which a client is discharged influences the length of time that the client will remain housed. Satisfaction with one's living environment, personal preferences and social support structures all influence the client's length of stay (Anucha, 2003; Gnaedinger, 2007) and resilience in crisis situations. In Anucha's (2003) eviction research and Gnaedinger's (2007) evaluation of supportive housing for hard-to-house seniors, the participants commented on the importance of having flexible environments that provide the "right fit" for those with diverse needs, as well as accessible skilled staff who understand how to effectively support tenants. A lack of appropriate resources, inflexibility, and poor support are common traits in unstable tenancies, causing the "revolving door" syndrome for clients who need assistance to remain housed. The two most common reasons for evictions in both the public and private sectors are rent arrears and behavioural issues (Acacia Consulting and Research, 2005; Anucha, 2003). Due to the built-in care component, AL is able to accommodate a frailer, marginalized population that often lacks alternative resources for housing and care. This makes the issue of eviction and its prevention even more pertinent.

3.1 Financial Evictions

Though AL is considered affordable as it is prorated, based on the client's income, a large population of AL residents are one cheque away from falling into rent arrears. Many elderly have limited incomes, so any unanticipated additional expenses

(dental work, new medication that is not covered by Pharmacare, new morbidity, etc.) may present financial hardship and cause the client to fall behind in rent payments. The AL program has a waiver process to decrease the rent for struggling clients. However, if the client has $250 left after paying monthly rent, he/she will not qualify for the waiver as this amount is considered enough for personal expenses in AL. If the client's family is involved, they can sometimes help the client out temporarily. Still, many clients feel too ashamed to go to their children for such help or they may deny themselves the necessary help to save money or to leave an inheritance behind (Mancer & Holmes, 2004). The amount of support that a client seeks usually reflects the client's knowledge of the system, cognition, and the strength of his or her personal support system. When a client has a healthy relationship with her/his family, the family commonly acts as an advocate to obtain necessary assistance and provide required support. Many families are closely involved with the client's finances and may have power of attorney, or they unofficially help the client to manage bills. As a result, financial evictions are rare in this population. When finances become an issue, the AL case manager is able to access professional help around money management, medical assessment of cognition and treatment, as well as addiction outreach support, if that is the issue.

Hard-to-house people are in the same precarious financial situation. Due to their disabilities, they often collect provincial social assistance but have no other sources of income. To make matters worse, their addictions exert extra pressure on their already poor money management skills, making financial eviction more common. Hard-to-house clientele frequently lack a good social support system; they do not know how or may not want to look for help, as they may feel disillusioned with the system (Anucha, 2003). One

issue that compounds the problem of money mismanagement is the government policy of providing social assistance cheques directly to the client. Known as “welfare days”, the time of the cheque retrieval is noted for an increase in drinking and drug activities around the AL site. Some clients spend the money on their addiction without any plan for paying rent or other expenses and, as a result, go into rent arrears. The AL case manager’s challenge is the scarcity of resources to support this problem, both professionally and socially. When support services are accessed, hard-to-house clients frequently alienate these connections due to their choices and life style (Greenberg, 2007). The most common interventions are referrals (a) to social workers for money management or (b) to the medical team for competency assessment and (c) voluntary addiction counselling. If the client is not capable of managing finances, the public trustee is a potential option. Unfortunately these clients are commonly turned down by the public trustee office as they are unable to pay the cost of having a Public Trustee, thus limiting the options to support hard-to-house clients in AL even further.

To counteract the financial issues, the Hillside Terrace operator and the AL case manager have attempted to tighten up the screening criteria for clients who need assistance with financial management, requiring clients to have their finances in order prior to moving to AL. Sometimes this works, however the financial management for the hard-to-house clients who are already in AL remains an issue that is increasing with the trend to social housing that specializes in hard-to-house populations. According to Acacia Consulting and Research (2005), some social housing programs offer rent banks to their tenants. Tenants can cash their government checks right on site, to assist the client with financial management and bill paying. This is not currently an option at

Hillside Terrace, due to workload issues and not having designated money management as a prescribed service for the site. If further AL sites are developed for hard-to-house clientele, rent banks may be a possible solution for this issue.

3.2 Behavioural Eviction

Behavioural evictions are the second most common type of eviction from AL. For the elderly, inappropriate behaviour may begin or exacerbate with the progression of dementia, as a result of addictions, or because of the poor fit of environment to the client's personality. Progression of dementia and the associated behaviours usually indicate a client's changing needs for a more supportive environment. The process for transitioning the client out of AL and frequently to residential care because of cognitive decline is well developed and is not the focus of discussion here. The major problem are the behaviours associated with the use of alcohol/drugs and/or generally poor choices on behalf of either the elderly or the hard-to-house, though this is more prevalent in the hard-to-house group. The elderly are more likely to rely on alcohol as a drug of choice, while the younger population tends to use illegal drugs (Greenberg, 2007). The presence of "happy hours" (open bar) in some AL settings for the elderly may trigger old habits and contribute to addictive behaviours, indicating the importance of the initial screening for the right "fit" for the potential client. In my experience, AL does not have as structured an environment as is commonly believed in the medical community. The level of oversight is very minimal and is determined by the scheduled tasks around the client's care plan. Since the client is considered competent, the operator or the AL case manager does not interfere with the client's habits as long as those habits do not impact on the rest of the residents in AL. However, once the client's choices lead to escalating violence,

altercations with staff and tenants, poor upkeep of the apartment and so on, the operator attempts to address the issue with the client. Unfortunately, due to the lack of a standardized process for dealing with tenancy issues, the AL case manager is notified randomly and sometimes too late to intervene effectively, as clients have already been served eviction notices and are expected to vacate the premises.

The tolerance of each AL site for unruly behaviour is usually proportional to (a) the nature of the behaviour, (b) the risk it imposes on the surrounding environment, (c) the operator's experience and (d) the type of population housed. The behaviours are categorized by risk, depending on how much potential damage they can precipitate. Generally, it is up to the operator to allocate the risk level and to determine how long he/she is able and willing to deal with the situation. Any evidence of physical violence, threat or intimidation will propel the situation into a high risk category and escalate the urgency of action. To give an example, low risk behaviours may include housing a pet in a non-pet building, or allowing relatives and friends to live in the apartment longer than permitted in the tenancy agreement. Medium risk behaviours may include smoking inside the apartment and verbal aggression; while high risk may be active drug dealing in the apartment, altercations with staff and the tenants, or any form of violence. Since each situation is very individual, depending on the character of the client and the circumstance, the same situation may entail more than one level of risk and, as a result, it will also require different interventions. Also in the hard-to-house population, often it is not the clients themselves but their acquaintances that cause a problem (Anucha, 2003). Regardless of the source of the issue, the expectation is that the associated tenant will address it with that acquaintance or seek the assistance to do so. The failure to address the

problem will trigger eviction, an unfortunate trend for this population (Anucha, 2003). The non-secure premises characteristic of AL sites makes screening visitors difficult and, ultimately, the responsibility of the tenants. As a result, any history of the client being evicted due to the behaviours of his/her acquaintances is carefully considered and screened by the operator and the AL case manager on the initial admission of the client. The tenancy agreement may include certain conditions related to visitors, if such a client is accepted at the AL site.

The main intervention around behavioural issues is conflict resolution attempts by AL staff and the home care workers, as an immediate response to any given situation. Once again, the urgency of the response and the tolerance of the operator depends on the gravity of the behavioural issues. Since individual operators are responsible for training their staff, conflict resolution techniques may differ between sites. Thus, consideration must be given to mandatory conflict management courses being a part of the standard training of AL staff. For behavioural management, there should be an ongoing dialogue and proactive planning, involving the client, the operator and the AL case manager, on how to prevent further incidents. Because of workload and other competing priorities, responses from VIHA professionals may be delayed. This puts added stress on the AL personnel at the site and on the AL case manager to expedite the referral process to other disciplines. Improved processes for communication among the VIHA sectors are principal in such cases.

3.3 The Cycle of Eviction and the Points of Intervention

Regardless of the reason for the eviction, the process for housing instability follows the same path. It starts with the client being considered for the site. At this point

the operator and the AL case manager have the most impact on establishing the expectations and drafting a contract of services and rules. If the client has an eviction history or other qualities that may lead to potential problems (e.g. smoking), the conditions of the tenancy can be discussed and articulated in the tenancy agreement. By signing, the client agrees to the conditions. Since the operator relies on the AL case manager to indicate any potential issues, effective communication among the professionals and the client is key. Any advocating or gate keeping happens at this stage. Once the client is in the AL site, transitioning an uncooperative client out becomes more difficult.

The next step in the process is an incident (e.g. default on rent payment or disruptive behaviour). The operator serves a verbal warning or may immediately issue a warning letter. Warnings may be repeated depending on the severity and frequency of the incident. Ideally the AL case manager will be notified of the incident and have a chance to refer appropriate supports to address the issue. The length of time between the warning letter and the eviction notice varies depending on the severity of the incident and the operator's tolerance. For AL, no standard time frame guidelines for each step exist, in contrast to the *Residential Tenancy Act*. If the client does not comply with the warning letters, the operator serves the client an eviction notice and usually notifies the AL case manager. Unfortunately, the typical intervention attempts happen after a repeated warning notice is issued, by which time a crisis has developed. Once the eviction notice is issued, eviction prevention is no longer possible but, unfortunately the AL case manager is most often notified and the tenant seeks support at this later stage (Chamberlain & Johnson, 2000). Interventions are complicated by a convoluted referral

system and the lack of time to act. Evicted tenants are often more concerned with finding new housing and storing their belongings than preventing the imminent eviction. The lack of understanding of their rights and complacency about looking for help is compounded if they have a poor personal support system. Delay in prompt communication between the client and the stakeholders takes up time that is needed to intervene and support the client in retaining stable housing. In general, if evictions were seen as an indicator of the need for more comprehensive support for clients, and occurrences of eviction were tracked, the data could be used for further investigations of eviction prevention and initiating the required supports (Acacia Consulting & Research, 2006).

The primary means of preventing evictions is the early identification of clients at risk, and the development of individualized supports (Slatter & Baulderstone, 2003). To facilitate this, partnership building and effective communication among the involved stakeholders are essential. Strategies such as information and advice to tenants and landlords, counselling and referral, mediation and outreach fall under preventive and supportive services that used successfully in some jurisdictions (Acacia Consulting & Research, 2006). Unfortunately, the business of dealing with clients in crisis can undermine the initiation and maintenance of preventive interventions.

3.4 Rights of the Landlord and the Tenant

In the common rental population, the *Residential Tenancy Act* (RTA) offers basic protection for renters regarding matters that fundamentally affect the affordability and one's sense of security in one's environment (Spencer, 2004b). The RTA was implemented to balance the interests of landlords, who own the property, and the tenants,

who are paying to use it. It addresses such issues as (a) security of tenure, (b) security of damage deposits and their return at the end of the tenancy, (c) the basis for evictions, (d) who is responsible for regular "wear and tear" of the property, and so on. Most importantly though, the RTA provides for arbitration of any tenancy matters. Since AL is not under the jurisdiction of the RTA, its timelines and its structure do not apply to AL clients. Issues that are regulated by clear guidelines in the RTA are open to free interpretation by the AL operators and are therefore addressed differently among the sites. This lack of standardized practice and an absence of solid guidelines make it difficult to manage AL housing and result in the *trial and error* approach of the operators. Spencer (2004b) notes that the lack of provincial tenancy protections allow the operators' needs and interests to automatically trump those of AL residents. This suggests that AL tenants have no rights protection, are vulnerable to abuse and neglect, and have limited options regarding arbitration. Yet, there is a recognized need, among operators, for structured guidelines to tenancy management. Most operators of AL housing are not operating for the sole purpose of making money; they genuinely care for the tenants they house. In fact, the reason AL has managed to be successful so far may be because of the integrity of the professionals who are involved in its delivery. However, the need for legal protection for both the operator and the client is vital if AL is to continue.

While landlords seem to have all the power around the tenancy management and are free to change the conditions of tenancy when convenient, the ability to use that power is not quite so easy, especially when the clients refuse to comply with the eviction. Presently, if an AL client wants to dispute an eviction notice, the only way he/she can do it is through the courts. The court hearing can take a long time as it requires a thorough

investigation and there is no legislation or structure to streamline the process (as with the Residential Tenancy Branch). While the court hearing is pending, the AL client may reside in the AL setting until the decision regarding the eviction is finalized. Even then, if the court decides that the eviction is fair and asks the client to vacate, the client may choose to disobey the decision and remain in the suite. This means the operator must get the court's permission to hire a bailiff and remove the client from the property. This extra step extends the time further. To complicate the situation, during the whole time of the court hearing and dispute resolution, the AL client may live free of charge in the suite, as acceptance of the rent by the operators usually is construed to mean that the client has been reinstated to reside in the suite and the eviction notice is forfeited (M. Isaac, personal communication, April 10, 2008). Eviction is very costly to both the renter and the operator. On average, it costs around $2000 for the client to move and reclaim or purchase new possessions. For the operator, the costs are higher, including lost rent, legal and bailiff fees, the cost of client removal and disposal of the client's property, etc. The whole process averages $3000 for the operator of a subsidized AL site and $ 6600 for a private AL site (Acacia Consulting and Research, 2005). Since it is a tenancy dispute, no other stakeholders are involved and the costs must be completely absorbed by the operators. In addition, the decision of the court may be in favour of the tenant.

It is important to remember that AL serves frail clients with personal needs, who frequently do not have an alternative address to which they can go. The publicity of evicting frail clients to the street can be more harmful for the other stakeholders than tolerating the client's behaviour in the subsidized housing. This leaves the operator in the precarious position as he/she manages the site with many frail clients and is responsible

for assuring the peace and harmony for everybody, not just one individual. Moreover, sour experiences with transitioning a *difficult* client out may affect the relationship of the operator with the rest of the stakeholders, sabotaging any future potential for other *difficult* clients in accessing that AL site.

While the above situation may seem extreme, it underlines the importance of the stakeholders working together as a group and supporting the partnership with the client, rather than creating adversarial relationships. No one benefits from evictions and the experience is hurtful to all involved. Though for the majority of evictions, the client complies with the eviction notice, it remains important to ensure there is fair process for both parties, the client and the operator, and to advocate for and support the client through the transition, if the client is willing to accept such assistance. Presently, the lack of a legal structure for tenancy management offers no legal protection for tenants. Without a sufficient legal structure the dispute resolution is drawn out and costly and there is no other neutral body available to represent and balance out the rights and interests of the involved parties. The only tenant rights that AL residents have are the ones they sign for in the tenancy agreement. This makes fair tenancy agreements vital and emphasizes the importance of having a neutral monitoring and enforcing structure for the regulation of fair tenancies.

3.5 Where Do They Go and the Cost to the System

In the global view of things, evictions affect everyone who is directly and indirectly involved with the client. As noted by Slatter and Baulderstone (2003):

> Evictions are costly. Everyone pays. The tenant household pays the personal, social, and financial cost of moving, disruption, uncertainty, and instability.

> Landlords pay the process costs, any net loss from arrears or repairs and vacancy costs. Agencies (and indirectly government) pay the resource costs of emergency accommodation and later intervention. Society pays the cost of social exclusion and lost opportunity (p.6).

According to Acacia Consulting and Research (2005), after eviction residents frequently move to a less stable environment. The reason for this is the high cost of private units and long waits for social housing. Some elderly clients end up renting regular apartments and have home care supports to attend to their needs on a scheduled basis; others move in temporarily with relatives or friends. Since the problems that caused the client to get evicted have not been resolved with a change of location, the chances are that the issues with tenancy and client behaviour will reappear. Using the family residence as temporary housing can put extra pressure on the relationship with the relatives and friends and potentially sabotage the scarce support that the client has. Caregiver burnout is a common issue for the family that cares for the elderly (Gnaedinger, 1999). Having a client move in with the family can precipitate a crisis for everyone involved. Additionally, an eviction, as part of one's rental history, makes a client less desirable for other housing providers and may limit subsequent options for housing. Hard-to-house clientele also rely on their friends, but they often end up on the street, as their relationship with other house providers, relatives and friends may already be compromised (Greenberg, 2007). Evicted residents frequently end up using emergency services, shelters, hostels and eventually hospitals, completing the cycle of ongoing transitioning and crisis response. According to Acacia Consulting and Research (2005), the estimated public cost of evictions ranges from $2000 to $10000 per month, depending

on the type of the services the client is using. The combined costs of health care, social and justice systems per homeless person per year may accumulate up to $40,000 (Greenberg, 2007).

In the fragmented health care system, the holistic picture of the client and his/ her needs gets lost in the succession of transitions through various departments. As the client moves on, his or her problems become somebody else's issue. The coordination of services is impaired and, though one of the VIHA's visions is *seamless service,* the reality is that there are numerous barriers impeding seamlessness. Slatter and Baulderstone (2003) identified some of the barriers: (a) workforce numbers and the spread of services, (b) complexity of existing service arrangements due to sectoral and geographic boundaries, (c) service and professional cultures, (d) confidentiality, (e) pro-active and re-active practice models, (f) lead agency protocol management, and (g) communication, language and definitions. All these factors affect communication and the operations of AL. This is especially obvious when there is a crisis for which prompt actions are required to support the client. The bottom line is that the cost, time, and effort required to re-house clients when they lose housing is far greater than measures geared towards assisting them in maintaining housing (Shern, et al., 1997). Though the research into cost efficiency of prevention programs is inconclusive (Acacia Consulting and Research, 2005), one thing is clear, there is a need for improved communication and more cohesive partnership among stakeholders, especially in the case of fragile clients who require flexible supports to remain housed and thriving in the AL environment.

In the next chapter, I will outline a proposed process for managing tenancies in AL, geared toward preventing these costly evictions.

Chapter 4: The Process for Tenancy Management

To develop a sound procedure for supporting the clients and their tenancies in AL, I reviewed a number of documents to determine the best process for tenancy management. Though the RTA does not officially cover AL residences, the majority of the AL documents were developed on that basis and included similar provisions for tenancy related issues. Since the RTA has withstood the test of time and our juridical system, the same trend is followed in the process of developing tenancy management guidelines for VIHA. The main documents I reviewed are: (a) the established tenant focused paperwork of the Hillside Terrace AL site and BC Housing, (b) the Residential Tenancy Act and suggested amendments for supportive housing, (c) guidelines for landlords in BC, (d) AL Operations manual for Interior Health, (e) a Vancouver Coastal sample of an occupancy agreement, (f) VIHA Home and Community Care Procedure Manual for AL housing, (g) some policies on exit and entry into AL from Northern Health, and (h) occupancy agreements between VIHA and AL operators. Some of the feedback regarding the gaps in the present system came via professional contact of being an AL case manger in VIHA and working closely with the stakeholders. The following suggestions and proposed guidelines are meant to be the first step in developing the best standards for tenancy management in AL in VIHA. The scope of this project does not include multiple iterations of the framework's process, as VIHA will use these recommendations as a starting point, and not the end point of policy development. The follow up will be undertaken by VIHA's quality improvement team.

4.1 Suggestions for the Tenancy Agreement

The tenancy agreement is the legal contract between the landlord and the tenant that lists the rights, responsibilities and rules to which both parties agree (Tenant Resource and Advisory Center, 2007). It consists of three parts: (a) information about the unit, landlord and tenant; (b) the terms upon which the tenant and the landlord agree (e.g. term of the occupancy), and (c) standard terms that set out the rights of both the landlord and the tenant (Residential Tenancy Branch, 2006a). The standard terms address topics of (a) security deposits, (b) pets and pet damage deposits,(c) inspection of the condition of the rental unit, (d) repairs, (e) payment of rent and conditions of rent increases, (f) assigning or subletting, (g) occupants and guests, (h) locks and access, (i) ending the tenancy, and (j) dispute resolution. Other terms than can be included in tenancy agreements are (a) house rules, (b) standards required by the Assisted Living Registrar, (c) care plans, (d) subsidy eligibility conditions, etc. (Residential Tenancy Branch, 2006a). Under the VIHA contract with the operators, the expectations regarding the tenancy agreement are minimal. That is, the tenancy agreement is expected to include (a) the definition of the premise and the services that will be provided to the AL tenant by the landlord, (b) monthly charge to the tenant, (c) conditions of occupancy and exit, and (d) resident responsibilities (VIHA, 2006). Since there is no standardized tenancy agreement in VIHA, the tenancy agreements vary among the AL sites. They all include the basic minimum expected in the VIHA agreement, but differ in particular details around standard terms. Such a disparity regarding tenant rights and responsibilities lacks clarity, compromises the tenants' awareness regarding tenancy issues, and leaves the operator vulnerable for dispute resolutions that may not be in his/her favour, when the

disputes involve issues that are not mentioned in the present tenancy agreements. Since the operators also vary in their experiences of managing housing, a standardized tenancy agreement template would provide them with concrete guidance for their practice, and help the health authority to provide uniform advice when the operators seek help around tenancy issues. The RTA based tenancy agreement is well known to most renters, experienced house providers and the judicial system, and could provide the model with some adaptation for a standard AL tenancy agreement. To ensure its versatility and adaptation the input of the AL operators will be essential. Eviction prevention starts from the moment the operator and AL case manager meet the client and consider him/her for the AL site. The tenancy agreement is a vital step for ensuring housing stability and mutual understanding of the terms for residing in AL. The standardization of the tenancy agreement has to be the first step in successful management of AL.

4.1.1 Fixed term option.

Under the RTA the term of occupancy can proceed on a monthly basis or extend for a set period of time (Residential Tenancy Branch, 2006b). In VIHA, there is only one option; tenancy agreements continue on a monthly basis. The reason for this is likely the hope that the client finds a secure housing option in AL and will remain there as long as possible. While that may be possible for the majority of the elderly population, the hard-to-house clients experience a higher rate of overturn in AL and may be better suited to a fixed occupancy. Such a condition lets the operator see if the client is able to manage in the setting. It also puts the onus on the client to do his/her best to remain housed. At the end of the fixed term, the client and the operator will reconvene to discuss the continuation of the occupancy and for how long. Any new conditions can be added at that

point, if the client is struggling. Though a fixed option may take some stability away from the clients, it gives the operator a guarantee that if the setting is the wrong fit for the client, his/her transition out is secured. In the long run, it would provide more options for difficult clients, when the operators feel threatened by the likelihood and costs of evictions and of managing unruly clientele for an indefinite period of time. According to Anucha (2003), the operators tend to choose clientele who will cause fewer problems and remain longer. The fixed term gives the AL case manager the ability to advocate for the client and give the client the benefit of the doubt. With a fixed term the operator will be more likely to agree to house these clients and give them a chance. Renegotiation of the contract may involve the client, the operator and, potentially, the AL case manager. If there are a lot of issues with the client, the fixed term occupancy also gives the AL case manager enough notice before the term ends to start arranging alternative housing.

4.1.2 Addition for client's responsibilities to apply for supplementation.

Because AL housing is subsidized, the monthly charge depends on the client's claimed income. When the client does not apply for all possible federal and provincial subsidies available to her/him, VIHA and BC Housing end up paying more from an already tight budget to house such a client in AL. The majority of the programs that provide subsidies rely on the client submitting the information on a regular basis, to check whether the client is still in need of the subsidy (e.g. Shelter Aid for Elderly Renters requires clients to reapply annually on their birthdays). The failure to do so forfeits the subsidy and the client's income drops as a result. To make it easier for clients to keep track, the ideal solution would be the standardization of the maintenance process for all subsidy programs. Without that, the present government system continues to be

difficult to navigate and access, but a review of the process is not scheduled in the foreseeable future. Therefore, the onus is put back on the client and though the AL case managers are responsible to ensure that the client is subsidized to his/her full capacity, some clients are non-compliant and fail to either file taxes on time or reapply for the subsidy. The chore of hunting such clients down and repeatedly asking them to reapply or to file is frustrating, as it takes time but does not guarantee results. Hopefully, by specifying the client's responsibility in the tenancy agreement, clients will have a clear understanding of their role in preventing eviction, and the AL case managers will have a stronger case for motivating clients to reapply for the subsidies.

4.1.3 Security deposits and pre/post inspection of the property.

While security deposits are a common practice in rental housing, the amount varies in AL sites as there is no regulation. Under the RTA, the damage deposit cannot exceed half of the monthly rent (Residential Tenancy Branch, 2006b). Some of the AL sites charge a standard amount varying from $300 to $1000 as a damage deposit, regardless of the client's ability to afford it. Setting the damage deposit at half of the price that the unit is worth is unaffordable for the clients who are on disability or limited income. Regardless of the deposit being refundable, some amounts are too large for the client to amass before moving into AL. However, allowing a prorated amount to be put towards the damage deposit on monthly basis may offer enough flexibility for some clients, particularly those who are being discharged directly from the hospital or who are there on very meagre means. The downside is that the operator risks never getting the required sum to cover expenses, if the client's stay in the AL site is short, because of causing damage to the property. A second suggestion would be to prorate the damage

deposit similarly to the monthly rent. That will mean no standard damage deposit. With both the monthly rent and damage deposit depending on the resident's income, BC Housing could be asked to supplement if the deposits are too large for the client to afford. An agreement between BC housing and the operators could stipulate BC Housing as the guarantor. This would allow the operators to bill BC Housing the outstanding amount of the required damage deposit, if the suite sustained damage and the operator needed the damage deposit to cover associated expenses. Although such a suggestion may be a "hard sell" in times of financial restraint, it would make AL more affordable to clients with limited income. This fits the initial vision of housing affordability upon which AL was based.

Also under the RTA, the operator can keep the damage deposit only if there is evidence of property damage. To prove that such damage was not present before the client moved in, there is a need to institute pre and post inspections of the rental property. RTA supplies a form that could be easily adapted for AL. The current practice of inspections varies in AL, due to the lack of regulation. To ensure the tenant protection and their ability to retrieve the damage deposit at the end of tenancy, property inspection is a must, a copy of which must be shared with the tenant on the move in and the move out. The same documentation should be used if BC Housing accepts supplementing the damage deposit amount.

4.1.4 Ending the tenancy agreement.

Under the RTA the standard time for notice of vacation is 30 days before the end of calendar month (Residential Tenancy Branch, 2006b). Some reasons for ending the agreement include (a) non-payment or repeatedly being late with rent payments or (b)

causing interference or risk to the health, safety, or property of another resident or the landlord. The same time frame is expected if clients decide to vacate per their own choice. Although the majority of AL sites in VIHA follow the same time frame, some extend it to two months with the right to charge two months worth of rent if the client vacates the premises sooner, for whatever reason. This includes the occasion when a client's health has changed and he/she is being discharged from the hospital to a residential care home with the assistance of VIHA. When this happens, client's families report feeling trapped financially. While one can argue that two months notice is a term of the tenancy agreement, clients frequently overlook the small print and miss those details that differ from standard rental agreements. The euphoria or ambivalence of moving into an AL residence erases the details of the conversation. Unfortunately, those details become vital when it is time to transition out. My recommendation is to standardize the notice of vacation to 30 days among all the AL sites, for the following reasons. First, it is the time frame people are used to, and second it is a fair amount of time for the AL case manager to fill the vacancy.

The only time when the termination of AL residency has to be expedited to 48 hrs or less is when the client is violent and placing the residents, staff and the property in danger. I also believe this guideline applies to elderly residents when they become unfit for the AL environment any longer. As a danger to themselves, they are expected to move to a residential facility. According to the first available bed policy, once the eligible client is matched to a bed in residential care, he/she must accept it and move into it within 48 hours from the time of notification (BC Ministry of Health, 2002). By matching the time frame of occupancy termination with the move in to residential care, the client is

given no choice but to accept the care environment that matches his/her current needs. It is important to make it clear to the family that the client is not eligible for AL any longer and will remain in AL only until a more appropriate care environment becomes available. If the family chooses to refuse the first available bed in residential care, their option will be to take the client home as, under the law, the client cannot continue to stay in the environment that is unable to accommodate his or her needs. Including this term in the tenancy agreement will inform the client and the family regarding this condition at the time of acceptance into AL housing. The same point is reiterated in a different format in the tour information (Appendix A) by the AL case manager to ensure the client and the family understand the eligibility criteria for AL housing and the terms for termination of AL residency.

To ensure the transition to residential care is seamless, the communication among the residential care coordinators and the AL stakeholders needs to be improved. It is critical that the AL case manager and the operator are notified when the residential bed is offered and refused by the AL client, as the timing will dictate further actions of all the parties around the transitioning of the client out of AL.

4.1.5 Addendum to the tenancy agreement.

When the operator and the AL case manager become aware of potential issues that may affect the stability of the client's tenancy, an addendum to the original agreement should be a useful tool for addressing the concerns with the client. An addendum is developed separately from the overall tenancy agreement and is appended to section 43 "Other". The addendum can be directed toward any specific issue that has caused problems in the past and serves as a contract for what the client must do in order

to address it. For example, if the client is known to have friends over that cause havoc in the building and intimidate the residents, the addendum would include a clause that limits the number of people that can visit at one time and specify the times when they are allowed to be in the setting. By separately articulating that the client is responsible for the actions of his/her friends, and guarantees not to participate in the disruptive or illegal activities or give access to anyone who participates in such activities, the client is reminded of what he or she must comply with, in order to live in the AL site. Such a contract is discussed explicitly with the client, giving him/her an opportunity to contribute ideas for addressing the issue. It is important to be transparent with clients, and accept them as they are, but at the same time the safety and peace of the rest of the residents is equally important. By talking about issues, the operator offers help and invites the client to partner in addressing the issues. If the client feels the contract is not feasible or presents a lack of insight and judgement, alternative options and housing can be explored at that point. This saves the time of moving clients in and out of an environment that they do not think they can sustain.

The addendum will vary in content, depending on the issue that has caused the housing instability. The main factors in developing the addendum are open communication and transparency among the stakeholders. The addendum gives the operator an extra guarantee that the client will do his/her best and is willing to partner, while the AL case manager will provide the connections with potential resources in the community. The efficiency of this tool will depend on the established relationships among the stakeholders, their communication habits and the willingness of the client to

honour the contract. Hopefully, the early identification of the clientele with high support needs will provide the timing and the support these clients need to remain housed.

4.2 Roles of the Involved Stakeholders and Lines of Communication

The generic process of tenancy management and the roles of the three main stakeholders may be found in Appendix B. The main principles are timely communication, transparency and the notion of mutual partnership and support. The common goal of tenancy management is successful tenancy for the clients within a supportive environment and stable housing. Only by embracing the involvement of the clients in the process will this be possible.

4.3 Tenancy Management in Assisted Living

While the expectation is that clients will move once the eviction notice is served, some clients resist it and try to find a way to dispute the notice. Given that the client was aware of the consequences of the issue far in advance and there were plenty of opportunities and the necessary support to change the behaviour, any dispute resolution has the potential of being ruled in favour of the operator. Still the dispute resolution process is timely and requires a neutral representation that AL housing does not have but for going through a court hearing. One can only hope that the environment of AL site is supportive rather than adversarial. With that in mind I have developed the following process for addressing two potential issues that cause evictions: rent arrears and behavioural problems. Regardless of the process, one needs to remember that the best management is prevention and everything needs to be done to avoid serving the client the eviction notice.

4.3.1 Proposed process to manage rent arrears.

1. The first business day after a client's cheque bounces, the operator contacts the client to clarify the issue and obtain payment or serve the client a written warning. The warning letter stipulates that the client has ……days to provide the required payment. Failure to do so, may result in the client being served a 48 hour eviction notice.
2. The operator sends a copy of the warning letter to the AL case manager and keeps a copy on the client's file. Another copy is shared with involved family members.
3. The operator also notifies the AL case manager by phone, who then follows up with the client and the family and explores the reasons behind the rent arrears.
   a. If the client is unable to afford rent due to other high expenses, the AL case manager considers assessing the client for AL waiver eligibility. If eligible, the AL case manager discusses backdating the start of the waiver by a month to cover the rent arrears. The client will still be expected to pay the new reassessed rate for that month. If not eligible, see step b.
   b. If there are issues around financial management, an urgent referral is sent to social services for client assistance with managing finances and to determine if the client is eligible for other funding.
   c. If the client appears incompetent of managing finances, an urgent referral is sent to the mental health outreach program requesting an assessment of the client's competency. If the referral response time is too long, the family physician might be consulted with the same request. If the client is deemed incompetent, the AL case manager and social worker assist the

family to establish the power of attorney. If the family is not willing or able, the same request is forwarded to the Office of the Public Guardian and Trustee. The outcome of the assessment and actions taken are communicated to the operator.

4. The AL case manager keeps the lines of communication open with the operator, the referred professional and the client's family (if involved) regarding the progress and plans to support the client.
5. If the client is unable to pay rent arrears for the last month in a lump sum, the operator considers prorating the amount of the rent the client has to pay immediately to cover the expense. A new tenancy agreement is drawn to articulate the debt and the arrangements for payment of the outstanding rent.
6. The second time that a check bounces; the operator repeats steps 1, 2 and 3. In this case the warning letter will stipulate that the next repeated occurrence of rent arrears will lead to an eviction letter, and the client will lose his/her housing.
7. The AL case manager follows up with the client again, regarding the reasons for the rent arrears, how the client might be supported, and the need to start considering other housing if another cheque bounces.
8. Repeat step 5
9. If the client is competent, has insight into the gravity of the situation and the check bounces a third time, the client is served a final notice re: rent arrears which also serves as an eviction notice. The client has 30 days to vacate the premise. The operator must alert the AL case manager prior to serving an eviction letter.

10. The AL case manager addresses the need for alternative housing, explores what options the client has considered, helps the client to review his/her housing options, and assists the client to make arrangements for the move.

It is important to recognize that the tolerance of each individual operator to dealing with rent arrears varies. Some operators are more lenient and give the client another chance; others know that they will never recover the full amount of rent and do not want to prolong the process. Any referral process takes time and the operator must be willing to work with VIHA to provide the client the supports he or she needs to succeed. Unfortunately, sometimes time required to establish needed support may exceed the tolerance of the operator.

As this proposed process is meant to serve as a starting point, there may be potential adjustments required e.g. in frequency of serving the eviction letters so as to accommodate the necessary time to intervene. To negotiate feasible and reasonable expectations among the involved stakeholders, more discussion needs to occur around the proposed management of rent arrears.

4.3.2 Proposed process to manage behavioural issues.

Any violent outbursts, threats or destruction to the property bypass the proposed process and the client is removed via police assistance and is served notice of eviction immediately; the conditions should be outlined in the tenancy agreement.

1. On the first business day after a client exhibits a behaviour that causes serious disruption to the peace and safety of the fellow residents, the operator contacts the client to clarify the issue and serves the client a written warning. In the warning the operator summarizes the events and the effect on the rest of the residents and

the AL environment. The operator states his/her expectations as to how this issue should be addressed and expresses lack of tolerance for any repeated behaviour along those lines.

2. The operator sends a copy of the warning letter to the AL case manager and keeps another copy on the client's file. If the family are involved, the same documentation is shared with them.
3. The operator notifies the AL case manager by phone. The AL case manager follows up with the client and the family and explores the reasons behind the behavioural issue. The kind of intervention by the AL case manager is determined by the nature of the incident.
    a. If there is any suspicion that the client's behaviour is related to a change in his or her health, the AL case manager contacts the family physician and asks for a medical assessment. Further referrals may be required to determine the nature of the client's changing behaviour. In case of the client being deemed incompetent of the person, the AL case manager initiates the transfer process of the client out of AL into a residential care facility, if eligible.
    b. If the client is competent and exhibits lack of consideration for the rules of the facility (e.g. smoking inside the suite), the AL case manager revisits the rules and consequences with the client and explores what kind of supports may be needed for the client to change the behaviour. Depending on the suggestions, the AL case manager will refer the client to another professional, e.g. the physician to discuss smoking cessation or a social

worker to explore anger management techniques. The AL case manager may advocate to implement some environment changes to accommodate the client's habits (e.g. to negotiate a more convenient smoking place outside, to replace or repair heavy doors to improve access to a smoking room).

4. The AL case manager keeps the lines of communication open with the operator, the referred professional, and the client's family (if involved) regarding the progress and the plans to support the client.
5. The AL case manager follows the client closely to review the progress of the interventions and to provide emotional support. This may be regular (e.g. weekly) checks either in person or on the phone to assess how the client is coping.
6. The second time the unacceptable behaviour occurs, the operator repeats steps 1, 2 and 3. Once again the operator summarizes in a warning letter what happened and when. The operator acknowledges any progress of the client in working to resolve the issue. Once again, the operator will state that this kind of behaviour is not appropriate and if repeated again will lead to an eviction notice, and the client will lose his/her housing.
    a. Behavioural adjustment takes time to occur, so the operator may follow *the third strike is out* rule if the same behaviour is being repeated.
    b. If a new set of unacceptable behaviours surfaces, the operator needs to start from the beginning and treat this as a new occurrence, going through steps 1, 2 and 3.

c. Regardless of the time in between the similar incidents, the third notice will be an eviction. The operator does need to be reasonable and give the AL case manager time to establish supports for the client. So once again, regular communication among the stakeholders, regarding the progress of the interventions is primary.

7. Once notified of a second behavioural outburst, the AL case manager will follow up with the client again regarding reasons, ways in which the client could be supported, and the need to start considering other housing if the unacceptable behaviour occurs again.
8. Repeat step 5
9. If the client is competent with insight into the gravity of the situation and the behaviour occurs again, the client is served a final notice of the behaviour, which also serves as an eviction notice. The client has 30 days to vacate the premise. The operator alerts the AL case manager prior to serving an eviction letter.
10. The AL case manager investigates a move into alternative housing, explores what options the client has considered, helps the client to review all his/her housing options, and assists the client to make the needed arrangements for the move.

Similar to the financial evictions, the frequency of the warning letters will reflect the tolerance level of the operator and the degree of risk associated with the behaviour. Any behavioural interventions require both conflict resolution skills and the ability to be flexible to accommodate the client and the environment. Ongoing communication among the stakeholders is a must, considering that behavioural adjustment and any related interventions take time to take effect.

I find it difficult to suggest any feasible timeline as the response of the operators and other stakeholders needs to be sought prior to finalizing the above guidelines. Since more than one government department may become involved with the client, the proposed processes must be discussed with them, to ensure buy-in and to achieve a timely referral process. Considering the type of clients that AL serves, establishing the support system through referrals may be quite complex and will require the orchestration of numerous resources to respond to the client’s needs in a reasonable time. Eviction is an emergency and, as such, initiating preventive measures must be perceived as an emergency response and given utmost priority.

4.4 When the Eviction Notice is Served

While VIHA’s responsibility is to create the structure that supports the clients in AL, a *cookie cutter approach* may not work for everybody. The process for tenancy management as proposed above will only work if the client also puts some effort into it. After the first discussion with the client and with the interventions in place, frequently it is obvious if the client will be able to stay.

Nevertheless, while everybody is given the benefit of the doubt, the rights of the majority override the rights of one individual in communal situations. There will be episodes, regardless of the best intentions and efforts, when the client may have to be discharged to the street. Though there are projects that attempt not to evict at all, the techniques of achieving this are vague and the existing criticism indicates it is done to the detriment of the rest of the population residing in the site (Gurstein & Small, 2005). To reduce the frequency of discharging the client to the street, it is important to create a network of resources that the AL case manager is able to access, when AL tenancy is

abruptly terminated. There are other housing projects that target clients with mental health and addictions, or simply are catered to the low income population. The difficulty in accessing them comes from the structure around those resources; different departments are responsible for deciding the eligibility of clients and managing their access. Consequently, the AL case manager may not have any other options to offer a client who is being evicted. Currently, communication processes require AL case managers to inquire about potential housing opportunities from the manager of the AL services, who has the power to advocate for moving the client into a different environment. Throughout the process the client maintains the right to decide what option he/she wants to follow.

The best example of how uniform management and a variety of housing resources support the clientele is illustrated in the example of the Victoria Cool Aid Society. The success of Hillside Terrace in dealing with the hard-to-house population anchors on the variety of housing options that the Victoria Cool Aid Society manages. When the client does not fit into AL, the operator and the AL case manager have other Cool Aid housing options that they may explore with the clients. As a result, the client feels he/she is being supported regardless of the need to move. According to the operator's experience at Hillside Terrace, many clients who exhibit problem behaviour in AL seem to settle down in other housing settings (I. Munro, personal communication, Apr, 10, 2008). This indicates that the hard-to-house population is not homogenous and requires a variety of flexible housing options to trial, to ensure the best fit between the person and the environment.

Contrary to the choices available to the Cool Aid Society, the remaining AL operators do not have several housing options that they can offer to the client. Therefore, once the eviction notice is served, the client's options around housing dwindle. Having an eviction notice in the rental history impedes the client's ability to access other housing options. Both the client and the AL case manager have an interest in locating alternative housing options. However, the ultimate responsibility for finding a new home rests with the client. Thus, the client must make his or her best effort to avoid the eviction on the first place.

In this chapter, I have proposed two processes for tenancy management that are intended to avoid immediate eviction for AL clients in rental arrears or who have exhibited unacceptable behaviour. In the next chapter, I will assess their utility and acceptability by applying MacCourt's *Seniors' Mental Health Policy Lens*.

Chapter 5: Application of MacCourt's Framework to the Proposed Process of Tenancy Management

Although the proposed process for tenancy management is tentative as it will require more input from the stakeholders, I used Penny MacCourt's *Seniors' Mental Health Policy Lens* (SMHPL) to guide its development and to identify any potential gaps or unintended negative effects on the mental health and well being of the AL population. I chose to use this analytical tool in hopes of establishing a fair process that is based on best practices and promotes and supports the mental health and interests of older adults. I believe that the SMHPL is an appropriate framework to guide the development of the tenancy management process in AL, as it is focused on a social model of care that emphasizes psychosocial factors related to health (MacCourt & Tuokko, 2005). Though AL is not care, but housing with a care component, it also incorporates social tenets in its functioning and therefore fits what the SMHPL endorses. When AL principles of autonomy, privacy, personalization and family involvement are followed, they will promote the core principles of well-being, dignity, independence, participation, fairness and security that are identified by the SMHPL as a requirement of policies and programs that promote quality of life and well-being (MacCourt & Tuokko, 2005).

By focusing on both the individual and the social context, the SMHPL is applicable in AL tenancy management as the SMPHL provides the wide range of aspects that influence both contexts. The thorough design of the policy lens is based on healthy aging policy, mental health promotion and principles of population health determinants (MacCourt, 2004); it is meant to strengthen the capacity of government and non-government organizations that foster social environments and health services, that are

supportive of older adults' mental health (MacCourt & Tuokko, 2005). Capacity building among stakeholders is important in AL, since all are driven by one goal of delivering appropriate supports and housing for marginalized populations. Explicitly considering the seniors' input regarding their well-being enables me to incorporate it into the guidelines to address and to balance the interests of all stakeholders.

While the SMHPL mostly focuses on the older adults, I believe it may also be applicable to the hard-to-house population as they experience similar biases in service access. They may suffer from mental health issues and are also marginalized in terms of housing and health care services. Though their values, priorities and perspectives may differ from those of the seniors, I see a similarity in the need for flexible supports and stable housing. Since AL aims to foster a supportive environment for its residents and to encourage their well being, the incorporation of the SMHPL in AL best practices may lead to improvement of these social environments and, therefore, reduce the likelihood of mental health problems reoccurrence (MacCourt & Tuokko, 2005) and increase housing stability. Since many tenancy issues are influenced by the mental health issues of the tenants, the SMHPL will allow me to consider the best practices for mental health promotion of tenants and to address the associated issues in AL.

5.1 Application of SMHPL to the Tenancy Management in Assisted Living

The structure of the SMHPL is simple and is presented in a table format. It consists of ten questions. There is a section for additional comments following each question to expand on the answers as needed. After completing the questionnaire, one is encouraged to ponder on the findings by completing a summary and an analysis of the results, through which recommendations, negative implications, possible remedies and

needed collaborations are identified. The analysis of the results is meant to initiate discussion and assessment of the guidelines. I acknowledge that the SMHPL is the framework for a *process* of policy development and I cannot apply it fully as the final decision on the tenancy management will occur after the input of all the stakeholders, which is outside of the scope of this project. Nevertheless, I believe I am laying the grounds for the best practice in AL and that the project will be used to initiate discussion among stakeholders about the gaps in service and, ultimately, to incorporate my recommendations. Using the SMHPL framework will also ground my arguments regarding the steps for the proposed changes and give me an opportunity to educate the involved stakeholders about this tool and my recommendations for improving the conditions for mental health and well being of AL residents.

To apply the SMHPL I will primarily concentrate on the general process for tenancy management in AL. Though I am proposing two distinct processes to prevent financial and behavioural eviction, the common processes of those two policies will be compared against the SMHPL. These common parts include: the disrupting issue, the communication around it, partnership and care planning among the stakeholders regarding the ways to address it, and the action and evaluation of the client's progress, depending on whether or not the issue reoccurs. The only differences among two processes are the nature of the disrupting issue (behavioural or financial) as well as the specific actions that are negotiated to address the issue and reflect the individual circumstances.

5.1.2 Brief description of the guidelines.

To review, a short summary of the proposed guidelines follows here. Stakeholders will engage proactively to prevent the eviction and will establish concrete lines of communication and information sharing to reach this goal. In response to any issue that affects the well-being of AL residents or breaks the rules and regulations of the AL setting, the operator will engage the client and the AL case manager both verbally and in written form in an attempt to correct the behaviour. The AL case manager will connect the client with the available and relevant resources in a timely fashion, while the client will cooperate and accept professional help, in order to avoid eviction and successfully remain in the stable housing.

5.1.3 Application of SMHPL Questions to the Guidelines

SMHPL Questions: 1. Process Factors.

Process	Yes	No	Not Sure	N/A
a. Has the policy been developed in collaboration with those who will be most affected?		*X*		
b. Does the policy/program emphasize partnership and collaboration?	*X*			
c. Are seniors/organizations consulted? Involved?	*They will be*			
d. Are other relevant organizations/ sectors/Ministries engaged?	*They will be*			

NOTES: While the AL population was not consulted in this process, their needs and views were represented by the VIHA staff who work with and advocate for them

most often, and via the available research. The guidelines are targeted more to the operators and VIHA staff, than to the AL clientele. Though there is an expectation that clients will cooperate, the goal is to lessen the frequency and the impact of evictions. The Canadian Center for Elder Law Studies was consulted regarding the proposed process. The other AL stakeholders will be consulted once the first draft of the guidelines is ready to be reviewed. Ideally, all AL stakeholders would be engaged into the process as it evolves. In my current work position I interact with VIHA stakeholders and AL operators and have incorporated the ideas from work-related conversations into my own thinking.

SMHPL Questions: 2. Diversity.

Does the policy/program recognize/address the diverse needs, circumstances, and aspirations of marginalized/vulnerable sub-groups within the seniors' population?

Recognize diversity?	Yes	No	Not Sure	N/A
	X			

NOTES: While the same policy is applied to all, there is flexibility that depends on the degree of risk to the communal AL environment. The operators, VIHA staff and other stakeholders are advised through these guidelines to take the particular circumstances and medical information into account, while working to avoid possible evictions. In this way, the guidelines address the diverse needs and circumstances of individual members of the AL population. Obviously the client's willingness to work on the solution and the availability of resources to support the client are major factors in the outcome.

Does this policy/program avoid negative impacts on the following groups?

Avoids negative effects for?	Yes	No	Not Sure	N/A

Gays and lesbians	X			
Ethnocultural minorities	X			
Women	X			
Caregivers	X			
Poor	X			
Oldest old	X			
Mentally ill	X			
Cognitively impaired	X			
Aboriginal	X			
Disabled	X			
Chronically ill	X			
Religious minorities	X			
Long term care residents	X			
Developmentally delayed				X

NOTES: The purpose of the guidelines is to prevent eviction and supply the client with appropriate supports from the moment the client moves into AL. The guidelines emphasize the need for communication with the client and involved professionals. If the client's family is closely involved, they will be brought into the communication circle as well. The AL case manager will work closely with the client around his/her needs to develop the action plan to suit individual needs in the best way possible.

Besides eviction prevention, the guidelines target early detection of changes in the client's status. Cognitively impaired clients will be housed in AL as long as they are able to direct their own care. Once that ability diminishes and the client starts running into problems, the guidelines will be used to transition the client out to a more supportive and appropriate environment. The same is true for any long term care residents who must remain in AL until a more supportive environment is available to them. In both cases, increased supports will be provided until the client can be transitioned out.

Developmentally delayed clients are not eligible for AL settings due to the AL structure and lack of individualized supervision. Therefore, these guidelines are not

applicable for this group. Potentially, if the developmentally delayed client is able to function independently, an AL environment will be considered. In general, clients are considered on an individual basis for each setting. However, no developmentally delayed clients are residing in an AL environment in South island up to now.

SMHPL Questions: 3. Determinants of Health.

Does the policy/program acknowledge the multiple determinants of health?

Specifically will negative effects be avoided on:

Avoids negative effects for?	**Yes**	**No**	**Not Sure**	**N/A**
Physical health	*X*			
Social support networks	*X*			
Social environments	*X*			
Safety	*X*			
Income status	*X*			
Personal health practices and coping skills	*X*			
Access to appropriate health care	*X*			
Sense of physical security	*X*			

NOTES: Similar to the previous question, the proposed guidelines for tenancy management are meant to support the client as needed, in order to prevent eviction. The AL case manager explores resources together with the client to ensure they are relevant to the client's preferences and thereby supports his or her personal health practices and coping skills. By introducing the client to more resources in the community the social environments and networks are strengthened. Preventing the client's loss of his or her home is the best way to provide safety and physical security. Income status is addressed for clients who are struggling financially and need either better money management skills or a temporary reduction in rent to deal with unexpected expenses. The AL case manager

is able to provide timely access to the appropriate supports if notified early of a potential problem for the tenant.

On a more global scale the above determinants are also considered in terms of the AL community. By having a concrete process that deals immediately with issues that affect physical health, sense of safety, social environment and so on, these guidelines also support healthy living and a sense of home for the rest of the AL tenants at that site.

SMHPL Questions: 4. Accessibility.

Does the policy/program consider accessibility?

Consider accessibility?	Yes	No	Not Sure	N/A
Is pertinent information readily available?		*Not yet*		
Is it affordable?	*X*			
Are sufficient resources likely to be available in a timely manner?			*X*	
Is transportation readily available?				*X*

NOTES: As mentioned earlier, the lack of standardization among AL sites undermines any structured approach to tenancy management. Presently AL sites vary in the amount of information they include in their tenancy agreements or resident handbooks. The proposed standardization of the tenancy agreement and the proposed tour sheet (Appendix A) provides a model for delivering the pertinent information to the AL client before tenancy. Once approved, information on eviction prevention would be available to all operators and VIHA staff in written format. I recommend that it also be made available at AL sites and on AL websites for current and prospective AL residents. The affordability of the process will be built into the operational costs of running the AL program. AL clients are not expected to pay for the available supports as they are eligible for those programs under Home and Community Services. The issue of providing the

appropriate resources soon enough to prevent evictions will need discussion by all departments that may be involved with the clients on an urgent basis. This discussion must take place during the review (and hopefully the approval) of the proposed guidelines by all stakeholders. Buy-in and prioritizing among departments is required to offer successful eviction prevention. Similarly the access to housing resources that are not part of the AL program must be secured. These points will be addressed by VIHA administration once the first draft of guidelines are considered and approved. Until then there is no guarantee that the needed resources will be available in a timely fashion. The issue of transportation is not applicable as the services are provided on an outreach basis and the client does not need to organize any additional transport unless he/she attends certain speciality groups. Transportation for moving the client in or out of AL has always been the client's responsibility and, though the AL program may suggest options, it does not provide any transport associated with the move.

SMHPL Questions: 5. Participation and/or Relationships.

Does the policy/program promote/support seniors' social participation and /or relationships?

Promotes participation and/or Relationships?	**Yes**	**No**	**Not Sure**	**N/A**
Within their social network of family and friends?	*X*			
Within the community?	*X*			
Does it promote seniors' inclusion in society?	*X*			
Does the policy/program reduce loneliness, and/or social and spiritual isolation?	*X*			
Does it promote/support a sense of belonging/mattering?	*X*			

NOTES: By identifying resources that matter to the client, the AL case manager may assist the client to establish and build on supports available in the community. The AL case manager offers support and services but the client takes the initiative in choosing among the options. If the family is closely involved, they are brought in for support, provided the client agrees. In my opinion, avoiding eviction will foster the client's sense of belonging and inclusion in the AL setting and in society. Individualized interaction with the professional may help the client to feel important and that there are people who care and are willing to help him/her. Ideally, within the AL environment the clients will initiate their own participation in the recreational and social opportunities that are available on site. Intensive interaction with the client has the potential to reduce loneliness or isolation, however a healthy balance is important as some clients become over stimulated by the heightened amount of the attention they are receiving and by more interventions around the issue that they can handle. While the client's willingness to participate is a must, the AL case manager in partnership with the client should help with decisions about prospective programming.

SMHPL Questions: 6. Independence.

Does the policy support seniors' independence, self-determination?

Support independence?	**Yes**	**No**	**Not Sure**	**N/A**
Does it provide opportunities to make choices?	*X*			
Is information, encouragement and support provided to facilitate choice?	*X*			
Does it promote coping skills?	*X*			
Does the policy/program reduce loneliness, and/or social and spiritual isolation?	*X*			
Does it build on the capacity of seniors and adjust to different circumstances?	*X*			

NOTES: The proposed guidelines offer choice and are built on mutual partnership. While one can argue that it is reactionary in nature, all AL clients are given choices within the setting and among programs offered, from the moment they move in. When extra supports are needed, the AL case manager acts as an advocate on behalf of the client, to ensure the client receives the required resources. Nevertheless, the choice of socially appropriate behaviour and the setting's rules is rigid, as the client must either follow the rules or look for other accommodation. At the same time, everything possible is done to mutually accommodate the client and the rest of the AL tenants. When the client decides to move, assistance is offered for that as well. Throughout the whole interaction with the AL case manager and the operator, the client is provided with full information and is given opportunities to contribute to the action plan on how to address the issue fairly. So, in general, if the client is willing to work together with the AL case manager and the rest of AL staff, a mutually beneficial solution that enhances the client's social network and coping skills can be the outcome.

SMHPL Questions: 7. Dignity.

Does the policy/program support seniors' dignity?

Support dignity?	**Yes**	**No**	**Not Sure**	**N/A**
Does it promote self-esteem?	*X*			
Is it respectful of seniors' privacy?	*X*			
Does it acknowledge the uniqueness of each individual?	*X*			
Does it consider individual versus collective needs?	*X*			

NOTES: The guidelines promote keeping people in their homes for as long as possible; self-esteem of an individual can be closely linked to their housing stability. It

cannot feel good to be evicted. This addresses the client's dignity and individual needs through an attempt to support the client so he/she will retain the housing. The client is given time and necessary supports to address an issue. Although self-esteem may be compromised by when a situation requires involvement of other people, the help is offered respectfully and the client has the opportunity either to refuse the help or to contribute to the individualized action plan, in which the client's needs are addressed in the context of the collective needs. There are limits to the tolerance and flexibility in the guidelines, however, depending on the degree of risk that the issue presents and the client's willingness to address the problem.

SMHPL Questions: 8. Fairness.

Is the policy/program fair?

Is it fair?	**Yes**	**No**	**Not Sure**	**N/A**
	X			

NOTES: The goal is to help prevent evictions. The current situation can be seen as grossly unfair to clients who are served an eviction notice and are not able to dispute it effectively. The proposed guidelines are an attempt to balance both the needs of both the individual and the rest of AL residents. The action plan is individualized to meet the needs of the client in the AL environment and the client has full input regarding the planning and outcome of the situation. The client is also given relevant information to make an informed decision regarding the consequences of his/her actions and available options for supports and other housing. The guidelines are less tolerable of the client's actions when other AL clients are placed in danger, either physical or potential. These conditions are to be articulated in the tenancy agreement before the client moves into AL.

Does it take into account the full costs and benefits of supporting the aspirations of seniors?

Please write in response where space is provided.
What are the benefits to seniors if policy is carried out?
The guidelines provide a standardized structure to address the issues that cause a loss of tenancy. They allow for early intervention and coordination of the required supports to address the issue before an eviction notice is issued. They allow the client to make an informed decision regarding the consequences of his/her actions and contribute to the plan of action. They are based on mutual communication and partnership and foster an environment of support and acceptance in AL settings.
What are the costs to seniors if policy is carried out?
The client is expected to take responsibility for the actions that threaten the tenancy, which may not be possible if the circumstances are out of the client's control e.g progression of dementia and memory loss. Some clients may resent the professional attention or feel as though their autonomy is undermined when encounters with the professionals are frequent. If the client's needs are very specialized, appropriate resources may not be available to support the client in AL and moving elsewhere becomes the only option. In the worst case scenario, there may be no appropriate place for the client to go. Finally, for some, family involvement may put additional stress on familial relationships. Consequently, the guidelines may not work for everybody.

SMHPL Questions: 9. Security.

Does the policy/program support seniors' sense of security?

Support a sense of security?	Yes	No	Not Sure	N/A
Economic security?	*X*			
Physical security?	*X*			
Opportunity to plan for future e.g., death; appropriate housing and services?	*X*			
Sense of belonging?	*X*			

NOTES: Any threat of eviction compromises a client's sense of the security. The guidelines are meant to prevent the loss of housing; however the client may still feel vulnerable to being evicted. As a result the client's sense of belonging could be compromised, regardless of the efforts of the operator and the AL case manager. The guidelines give several opportunities for clients to plan for the future – the outcome of that will depend on the client's insight and willingness to accept help. When the outcome is positive, keeping a client in the housing with which he/she is familiar and comfortable preserves the client's sense of belonging and physical security.

SMHPL Questions: 10. Cumulative Impacts.

Is consideration given to the cumulative impacts on later life of policies/programs targeted at earlier life stages?

Please write in response where space is provided.
The guidelines are designed to prevent loss of stable housing. For the hard-to-house population, stable housing may mean better quality of life and improved health and longevity, while for the elderly, it may also prevent premature transition to residential care and preserve an increased sense of independence. By preventing evictions, we

ensure that many events that may negatively impact an individual later in life are avoided.

5.1.4 Analysis of results.

The following has been quoted directly from the SMHPL.

Summate the columns

YES > NO? You are well on your way to a positive policy/program. But look for some ways it could be improved. Go back and determine if there are any policy changes that will yet increase the number of "Yes" responses.

NO > YES? Your policy/program should be re-examined for content and overall intent. Many needs, wants, and concerns of seniors are not being met. A good source of input is from seniors themselves - ask them.

NOT SURE > Either YES OR NO

You need to gather more information before proceeding with your policy/program. Your policy is not comprehensive or not holistic.

NOT APPLIC > Either YES OR NO

Go back and critically examine your policy. Are there many categories that do not apply to your policy or program? Or does much of the policy/program not apply to the needs, wants, and concerns of those it is intended to

be written for? (MacCourt, 2004, p.9)

The majority of the responses are positive. There are 1 **Not Sure** answers that will require further clarification in the discussion with the stakeholders, 2 **No** and 2 **Not applicable.** Thus, there is evidence that the proposed guidelines are developed fully enough to present them for stakeholder consideration.

Add Summary of Discussions

16 *Recommendation*

Recommendation	**Yes**	**No**
Accepted		
Accepted as revised		
Need more information to decide from whom, where	*X*	
Needs revision		

The final recommendation regarding the future of the guidelines will be made in the discussion with the operators, the other AL case managers and the managers of the AL department. All **not sure** answers will need to be discussed and addressed, if possible, prior to adopting the guidelines. The following is based on the personal analysis of the guidelines within the SMHPL.

Negative implications identified:

1. The ability of the AL case manager to support the client depends on the client's

insight and willingness to partner. Without that cooperation, the AL case manager and the operator will not be able to assist the client and the client will likely be evicted. These guidelines are based on the client's cooperation and conformity. Thus, they exclude the clients who are unable to manage in the communal environment with available supports or who may require specialized attention that is beyond the stage of AL. At the same moment the client's priorities and suggestions on how to address an issue may not be possible to accommodate (e.g. an individual who prostitutes herself may suggest that the AL site change its policies so she can bring her clients to her apartment). Such a client may feel patronized and not understood. Some clients may resent the intensive involvement of the professionals and refuse the assistance to their own detriment. Others may be prone to change their minds frequently throughout the interaction with the professionals, thus inhibiting effective communication and progress around the issue. Family may feel burdened by the expectation to be involved with the client's issues, especially if the client frequently experiences eviction.
2. The ability to create an individualized plan of action for the client depends on the availability of service resources. When resources are not available, the client's needs will not be adequately addressed and the client is likely to lose stable housing. The proposed guidelines do not address the lack of specialized resources in the community. The goal of eviction prevention must be supported by the rest of the health community to ensure a timely and relevant response to the client's needs. The response time may be too long for the operator to accommodate the client in the AL setting. Developing timely communication processes among all stakeholders enhances the efficiency of their mutual efforts.

3. By providing very clear guidelines for what is required to evict a client in assisted living, I may be educating operators on how to have more effective evictions. The potential negative aspect of this is outweighed however by the potential to benefit the clients who are, at present, without a consistent process for tenancy management.

Suggested remedies:

Possible remedies include more global suggestions on how to improve housing service for these marginalized populations and will require intensive preparatory work prior to implementing the guidelines. Though the following recommendations may not directly address the issue of how to improve the guidelines themselves, they indicate what needs to be done to ensure the success of the guidelines.

1. Training in conflict resolution and effective communication skills for all staff involved with client care.
2. Developing the strategies to address limited resources and ways to support clients who do not fit into the AL environment, but require stable housing and community supports. Explore acceptable options for supportive housing available outside VIHA and establish a process of accessing them.
3. Improve inter- and intradisciplinary communication. Ensure that the guidelines are supported by the rest of the health care team prior to their implementation. Everybody must be committed to responding in a timely manner, in order to adequately support clients and prevent evictions.
4. Consider the wishes of the family and the client regarding how conflict will be addressed prior to it arising. Documentation of the circumstances for which the family

wants to be involved is essential. Offer support to the family, if needed.

Partnerships, collaborators required:

The guidelines will need to be reviewed by all AL stakeholders: (a) AL management, (b) AL case managers, (c) the operators, (d) BC Housing, (e) Ministry of Health and potentially by (f) other Health Authorities that implement AL programs. Since the guidelines affect the work of other VIHA and non-VIHA departments, these will need to be contacted for a feedback as well (e.g. Elderly Outreach Services, Mental Health and Addictions, Home and Community Care, Office of the Public Guardian and Trustee, etc.). The final draft will undergo the review of the VIHA lawyer and administrative management.

Chapter 6: Further Recommendations on Supporting and Improving the Tenancy Management in Assisted Living

While agreeing upon guidelines for tenancy management is the first step towards improving the processes for the AL program, there are further recommendations that have to be considered as a context for successful eviction prevention. The primary prevention starts at the level of the clinician and the client, and the proposed guidelines are an attempt to give the clinicians a tool to follow, when communicating and troubleshooting the issues that threaten tenancy. In a more global sense, any successful intervention requires the support of the system and beneficial conditions within which to persevere. Similarly to the saying that it takes a village to raise a child, it takes the whole community to support an individual who is struggling in a communal setting. The community may be seen as the immediate environment where the individual resides, as in the AL site, or the system that provides access to the necessary services, as in the health care community. The interdependence of everybody's actions indicates the close intricacies of the health care design and, unfortunately, a weakness in one area influences efforts of the rest of the health care team. According to Kirby (2002), the issues around primary health care delivery include: (a) fragmentation of care and services, (b) inefficient use of health care providers, (c) lack of emphasis on health promotion, (d) barriers to access (care not available after hours and on weekends), and (e) poor information sharing, collection, and management. The same issues are true for the AL program. As part of Home and Community Care, AL inherited the bureaucratic processes around communication, information sharing and rigidity in accessing the resources. I

hope the following recommendations will help make the AL program more supportive of the clientele and the fellow clinicians.

6.1 Recommendation #1: To Improve Mutual Communication among the Stakeholders and Transparency in Service

This is probably one of the major points for successful operation of any program. In hindsight the guidelines themselves are nothing more than a tool for communication. The struggle comes from the fact that different stakeholders follow different processes that are not necessarily consistent with each other. The same is true for interdepartmental and intradepartmental communications in VIHA. The lack of understanding of each others' roles and the points of access stems from the impaired communication and also contributes to it. The inconsistent terminology causes further misunderstanding.

In order to promote efficient communication, it is important to educate the stakeholders regarding each other's roles and the governing processes that drive their practice, to standardize language (or at least provide the reference for terminology) and to establish the process for efficient communication that is clearly documented and available to the clinicians. Such simple actions not only improve the use of time, but also lighten the workload of the clinicians, contributing to overall job satisfaction and retention (Miller, Charles-Jones, Barry & Saunders, 2005). The task of keeping the information current may be difficult in the ever changing organization, but it is worthwhile in the long run. Clinicians are the ones who disseminate the information to the clients, laying the foundation for a long term working relationship and trust. Transparency in service and honest communication also builds a trusting relationship, contributing to a sense of partnership and inclusion.

In AL, the standardized tenancy agreement and a tour sheet are meant to improve communication with the client by clarifying the conditions for AL tenancy and the roles of the involved clinicians. The guidelines were designed to orchestrate and standardize the actions of the clinician when assisting the client with the tenancy issues.

6.2 Recommendation #2: To Practice with a Holistic View of the Client and Seamless Service Delivery

There are a variety of supports that are available to the client through different programs in VIHA and community organizations. Unfortunately, as the client moves along through the system, communication among the departments dwindles and the client is subjected to repeated reassessment of eligibility for services and programs. The biomedical approach (issue oriented) to service delivery still governs the mentality of the clinicians, their view of the client, and accessibility to services, often limiting access to needed resources. In terms of evictions and helping the client to maintain stable housing, the AL case manager is limited to the resources that are provided through the AL program. Any other specialized housing or community supports are difficult to reach due to the different management structure and access process. The struggle of accessing the new environment is accentuated by the limited time frame (as in eviction prevention) and the bureaucracy around it. The simple knowledge of what is available is limited and the agencies lack established lines of communication with each other. I believe, besides creating more specialized housing options for the hard-to-house and frail elderly populations, it is important to streamline the process of communication and the transfer of clients between departments and outside agencies. Resource availability is defined by the public and professional knowledge of them. Established strategies for access and

coordinated communication can improve resources flexibility. The client should be the focal point of any intervention and, as noted by Gurstein and Small (2005), the resources should fit the client's needs and not other way around!

6.3 Recommendation #3: To Foster a Culture of Support:

a) Within the Organization

While efficient communication and information sharing among the stakeholders is meant to foster a culture of support, more initiatives need to be considered to sustain the environment of collaboration. Time sensitive issues need to be addressed in a timely manner, which is only possible if the priorities between the supporting professionals are negotiated ahead of the time. I struggled with the concept of time when I was developing the process for tenancy management. It is not enough to arbitrarily pick a number, there must be mutual agreements among everyone involved, to ensure a feasible time-frame and commitment to organize the needed supports and assessments for clients facing evictions. This will only happen if the professionals consider a potential eviction as an emergency and therefore treat it as such. The education of stakeholders and thorough discussion has to be a part of the process for implementation of the guidelines, in order to ensure access to resources in a timely manner.

b) Among the Stakeholders

As for the stakeholders outside of the health care system, I believe VIHA has a role in supporting the operators by providing guidance and training. While legally the operators hold the whole responsibility for the tenancy issue with the clients (VIHA, 2006), it is a mutual obligation of all the stakeholders to ensure the well being and fair treatment of the clients in AL settings. Standardized training of the operators will

guarantee the AL philosophy and program are delivered to the highest standards. The educational opportunities will bring the operators together for capacity building and will ensure that they (a) have a support network outside of VIHA, (b) have a chance for dialogue regarding common issues and (c) can share and learn from each other's experiences. These educational opportunities should be targeted to the needs of the group, with the leadership being cultivated within the operators' group as well.

The proposed guidelines for tenancy management can serve to start the dialogue regarding an issue that is common to all AL settings. Hopefully, it will spark further collaboration among the stakeholders and more projects regarding best strategies in AL will be addressed through partnership.

c) For Tenants in AL

My main recommendation for supporting clients in AL is to develop a RTA like support system to streamline the legal issues and to fairly represent the rights of the tenant and the operator. While the government has considered bringing AL under the RTA, it has been two years already since the amendments were approved (Residential Tenancy Branch, 2006a), but they are still not enacted. The RTA-like support system may use the amendments as a guideline, however, knowledge of the legal system and the laws will ground the dispute resolutions. I think BC Housing should take responsibility for providing the tenants and the operators with some kind of legal representation in tenancy disputes. VIHA could support the process; however it faces a conflict of interests as it is closely involved with the operators and the tenants. BC Housing is neutral and far enough removed from client care to offer fair legal representation for dispute resolution around the tenancy issues. Their experience with housing management should be an asset in this case.

Another option for tenancy disputes in AL is for VIHA to hire a neutral adjudicator for tenancy issues and offer it as a service to the AL tenants and operators. The cost of such service may be offset by the annual fee that the operator has to pay in order to be able to access the service. Similar to the Residential Tenancy Branch, there may be a fee each time the service of the mediator is needed. I believe by providing this kind of service to the AL residents, VIHA could demonstrate leadership in client care and quality improvement in protection for clients in subsidized AL housing.

My last comment is regarding the affordability of the AL services and the need to standardize the prices and processes around damage deposits. In general, AL claims to be affordable as its rent and services are prorated to the clients' income. However, all of the extra costs that have been transferred to the family and the client are ignored in this statement (e.g. medical supplies, incontinence products, services that are not part of the AL package). While the client should share financial responsibility for the housing and services he/she receives, the issue of affordability should be closely examined, in terms of the extra costs charged by each specific building. I think the process around the damage deposit and the operator's tolerance regarding the expediency of its payment needs be reviewed more closely, as it is a barrier for clients on limited incomes.

While there are always ways to improve a program, I believe ongoing communication among the stakeholders, transparent seamless service among the programs and services and a global culture of support may be good starting points for quality improvement in AL processes. The proposed tenancy management guidelines will open the dialogue around the urgent issues. However, maintaining a process of effective communication and willing partnership will be an ongoing affair and, by fostering this

collaborative atmosphere, we may ensure that creating supportive environments for clients will be a successful new format for AL housing.

d) For Further Research

My last comments will be regarding the need to support ongoing data collection and research efforts around the programs that are being implemented in VIHA. My encounter with the lack of any statistical information, the absence of quality indicators, role descriptions of the main players or any built-in components for ongoing evaluation was frustrating and troubling. I see this as a barrier to adjust the innovative approaches according to the need of the targeted population and involved clinicians. I believe for the programs to be relevant and efficient, the evaluation has to be regular and performed on ongoing basis. After all, this is one of the ways of ensuring there is evidence for the government to continue to support particular programs in health authorities.

In terms of my project, it will be important to set the quality indicators prior to its full implementation and to develop the means to collect data to measure those at regular intervals. The timing for quality assurance evaluation can also be built in at the point of implementation to ensure it will occur regardless of any ongoing change of regular staff.

In addition to quality assurance, the data generation through my project should also address the gap in the information available about AL in Canada. This will support future research on evictions and the best organizational practices for the AL population in BC.

Chapter 7: Conclusion

As the health care resources continue to dwindle, the need for their efficient management remains an issue. In any innovation, it is important to remember that the needs of the people should drive the design of the program. What initially seems to be a great idea must be thoroughly and openly discussed among those it will affect. Solid structure and regulation are a must for the operation and support of AL. While the proposed process may take longer in the beginning, it will prove to be better in the long run and more cost efficient, by preventing changes and redesigning later to fit each new situation.

I believe AL has great potential. Regardless of its shortcomings it can work and successfully support the clientele in the community. The main issue of establishing the channels of the proper communications and supports should be addressed, to ensure that all stakeholders are given the opportunity to collaborate to the full meaning of the term.

It is possible to change the view of evictions from a labour intensive means of disposing of unwanted clients, to a symptom of a failure on the part of the involved professionals. If all stakeholders, including the client, do everything possible to avoid evictions, then it will become possible to operate a health region where evictions are virtually eradicated.

Appendices

Appendix A: PUBLICLY FUNDED ASSISTED LIVING
Tour information for the potential clients

What is publicly funded Assisted Living?

Assisted Living is a housing model that offers care and support services for eligible residents. It is governed by the *Community Care and Assisted Living Act* of 2002, and it does not fall under the regulations of the *Residential Tenancy Act*. Assisted living is registered and regulated by the Office of Assisted Living Registrar.

For complaint resolution for safety and health related issues in this assisted living building, please use the phone numbers on the brochure attached to this form. Any concerns surrounding tenancy, should be addressed with the assisted living office by contacting your assisted living case manger as per attached business card, only if the concerns were unable to be resolved with your operator.

How much does it cost?

Residents pay **70% of their after tax income for the full package of services** on monthly basis. The full package of services is not optional and will be charged to the resident regardless if the resident is using all the specified services.

Additional fees include: monthly BC Hydro surcharge, telephone, Cable TV, internet connection, spa, outings, etc. as specified in the tenancy agreement. Laundry may be coined operated.

To remain eligible for subsidized assisted living residents must file taxes annually. The assisted living rate will reflect the claimed after tax income and will be recalculated each October. If there is a discrepancy between the new assisted living rate and the resident's income, please contact your assisted living (AL) case manager.

______________________ ______________________

AL case manager's initials Resident's initials

What does VIHA's Assisted Living include?

a) A private, lockable suite that you furnish with your own belongings. The building will also have common dining and socializing spaces.

b) * Two meals a day (lunch and dinner) in a common dining room,
* weekly light housekeeping of your suite,
* weekly laundering of linens (sheets and towels)- if supplied by the AL site,

* social and recreational opportunities,
* a 24-hour emergency response system.

c) Scheduled personal care assistance, which may include help with bathing, grooming, dressing, and medication management as per discussion with your AL case manager.

Any other additional services that are not mentioned in the above description will have to be organized and paid by the resident (e.g. foot care, companion visits, accompaniment to the medical appointments, purchase of groceries, etc.).

______________________ ______________________
AL case manager's initials Resident's initials

Who is eligible to reside in Assisted Living?

As per Home & Community Care eligibility criteria, to access and to ***continue*** to reside in publicly funded Assisted Living the residents must have <u>all</u> of the following characteristics.

They:

1. Are eligible for Home and Community Care case management
2. Require scheduled personal care assistance
3. Require hospitality services (meals, housekeeping, recreation supports, emergency response)
4. Are able to <u>make decisions on their own behalf</u>, or live with a spouse who is willing and able to make decisions on their behalf
5. May be at significant risk in their current living environment (e.g. falls, isolation, poor nutrition)
6. Do not behave in ways that put the safety of others at risk
7. Have stable health condition(s)

People who are able to make decisions on their own behalf are:

1. Able to function safely with supports available in the residence;
2. Able to recognize the consequences of taking risks;
3. Able to find their way within the assisted living residence;
4. Able find their way back to the residence independently;
5. Able to communicate effectively; verbally or non-verbally so they are understood by any authorized caregiver or spouse living with the client;
6. Able to initiate a complaint either to the family or Assisted living Registrar
7. Able to participate in the development and regular review of their care plan, or make their needs known to the person they live with who then participates in the development of their care plan; and
8. Able to recognize an emergency, use an emergency response system or otherwise summon help, and take direction in an emergency situation.

What if my health changes?

Individuals may continue to reside in Assisted Living as long as their health conditions remains stable, they can make decisions on their own behalf, (or live with a spouse who is willing and able to make decisions on their behalf), and their care needs do not exceed what can be provided in Assisted Living.

In the event that an individual experiences a permanent decline in their health condition, a significant increase in care needs, or an inability to make decisions on their own behalf that cannot be reversed, a move from Assisted Living to a more appropriate setting will be compulsory as per *Community Care and Assisted Living Act* of 2002. Assisted living case managers will assess the resident's current status and determine if the resident may continue to reside in assisted living. If not, assisted living case managers will assist with the transitioning process with the aid of the family.

____________________ AL case manager's initials

____________________ Resident's initials

Appendix B: The Stakeholders' Roles throughout the Process of Tenancy Management

Stages / Roles	AL Case Manager (AL CM)	Operator	Client
The preadmission	- selects the client from the Pathways (computerized database for waitlisted clients) - screens the available information and liaises with the geographical case manager and other involved practitioners for its clarification - organizes a tour - identifies potential issues that may affect tenancy, communicates that to the operator and discusses what needs to be included in the tenancy agreement if to accommodate this client - considers what other supports the client needs to sustain successful tenancy	- records the information the AL CM communicates re: potential client and discusses any concerns around accommodation and the client's fit - prepares a copy of the tenancy agreement based on the discussion with the AL CM (including the addendum, if needed)	N/A
Admission and tenancy	- informs the client re: AL program and the conditions for remaining in this type of housing - gets the client to initial each statement on the touring information sheet once all the related questions are addressed (each stakeholder gets a copy of this document-Appendix C)	- tours the setting and informs the client re: the services and expectations around the tenancy for this setting - if any addendum to the standard tenancy agreement, discusses this with the client and clarifies the expectations	- clarifies any questions or misunderstandings re: AL program - by signing the tenancy agreement, indicates that he/she agrees to the specified conditions, takes on the responsibility for

	- informs the client re: roles of AL CM and the operator and the process for complaint resolution in AL, provides the client with the pamphlet re: complaint resolution if it is not specified in the tenant handbook for the site - develops a tentative care plan for the potential client with the client and the family - discusses and organizes any extra supports if the client needs them in order to retain the tenancy (e.g. continuous follow up with Elderly outreach services for mental health support and addiction counselling) - informs the client that will visit the client regularly to ensure he/she is successful in this housing (the frequency may decrease if the client is doing well)	- gives the client a copy of the tenancy agreement and lets him/her ponder prior to accepting the conditions - discusses rent and payment arrangements - negotiates a moving in date - on the move in date, completes the pre move in inspection with the client and gets him/her to sign the document that indicates the integrity of the suite	compliance with them and is making an informed voluntary decision re: accepting the AL housing - on the move in date, completes and signs the pre move in inspection of the suite if its conditions are acceptable - responsible for any move in arrangements
Dealing with an issue	- follows up with the client re: the issue - involves more professionals if needed - discusses with the client the ways to help the client to stay on track - explores the reasons for the issue and how the client is planning to address them - explores the client's understanding of the gravity of the situation and what the client's plans are for alternative housing and how feasible they are - involves the family in attempt to	- writes up a warning letter #1 to the client that identifies an issue (time, date, who was involved), the need to resolve it, the time frame around it and the consequences if it does not happen - gives the client a copy personally and discusses an issue with the client face to face (records this in the client's file at the site)	- seeks and accepts help from AL CM and other professionals around the issue - complies with the arrangement of the tenancy agreements and the warning letter - plans and organizes the alternative solutions for the issue (if unable , accepts professional help around the

	provide support and find alternative solutions for the client (done on permission of the client) - offers help with planning if the client decides to move out - lets the AL manager know if the client is resisting any support attempts and needs to be transitioned out, - asks AL manager for assistance re: accessing the housing that is not part of AL program (mental health housing, BC Housing) - lets BC Housing know re: pending eviction if it is ILBC 2 site (BC Housing is responsible for both shelter and hospitality)	- informs AL CM over the phone and sends a copy to the AL CM for the client's file in VIHA - if the family is involved, notifies them as well - repeats the above steps if the degree of risk is low - negotiates with the AL CM and other professionals through the process - the third letter is the eviction notice (the operator will decide which warning is final and will let the AL case manager know before sending the eviction note out)	issue) - plans and organizes other housing options if unable to stay in AL
Transitioning out	- helps the client to identify other housing options and arranges for the client to move there - offers ongoing emotional and informational support through the whole process	- serves the eviction notice and informs AL CM re: the date of the move out - sends a copy of the eviction notice to the AL CM for the file - does the post move out check to decide on the damage deposit	- chooses other housing option and moves as per eviction notice - has a right to refuse any assistance and plan own transitioning out - responsible for any move out arrangements - will not be discharged to the streets unless it is client's personal preference (the proper documentation will need to be signed in that case)

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