Restoring the comfort of home: Addressing the challenge of placing hard-to-house populations in seniors' social housing in British Columbia

by

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Ethics Statement

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Abstract

Since the early 2000s, tenants of seniors' social housing in BC have increasingly shared their buildings with younger persons who have severe mental illnesses and/or addiction issues. While this demographic shift does not neatly correspond with a specific policy change, academics, media sources, and the experts and stakeholders interviewed for this report all have suggested that it results from the prioritization of the hard-to-house by the provincial government. For many seniors, this new environment has produced a host of negative outcomes: increased levels of fear; greater social isolation; more disruptive and unpredictable living conditions; and exposure to criminal activity, threats, violence, and other disturbing or dangerous behaviors. This paper examines the emergence of this policy problem and explores possible policy solutions. It does this through a literature review, six case studies from American jurisdictions, and thirteen interviews with experts and stakeholders. Ultimately, the paper recommends two interventions: funding and creating training materials for resident service coordinators, and an environmental scan of the approaches currently being made by the more than 550 non-profit housing organizations which provide nearly 90% of British Columbia's social housing units.

Keywords: Seniors; social housing; elder abuse; mental illness; addiction; hard-to-house

Dedication

For my mom, Linda, whose love and support never wavered no matter how difficult the times. I miss you more than words can say. And for my clients, who inspired this journey. I hope I have lived up to your expectations.

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Glossary

Senior/older adult/the elderly	Used interchangeably to refer to persons aged 55 and older
Social housing	Refers to publicly-funded, subsidized housing in British Columbia
Hard-to-house	Persons whose difficulty in securing stable housing goes beyond issues of affordability. This is often due to mental illness, addictions, or other complex and intersecting factors.

Chapter 1.

Introduction

From at least the early 2000s onwards, younger persons with severe mental illnesses and/or addictions have been placed in seniors' social housing facilities in British Columbia. This appears to have been the result of a decision made by BC Liberal Party following the 2001 election to prioritize the limited supply of social housing for individuals struggling with complex issues such as homelessness, mental illnesses, or addictions. Age-mixing in seniors' social housing was not uncommon prior to this, but it typically involved a comparatively small number of younger persons with physical disabilities or less challenging conditions. This meant that the age-mixing which did take place did not lead to serious social strain or the problematic situation seen today.

While this demographic shift does not neatly correspond with a clear legislative change, it has real consequences for the seniors who are affected. Being housed with younger neighbours who are suffering from mental illnesses and/or addictions has been shown to lead to increased levels of fear, social isolation, exposure to threatening or violent behavior, and a host of other negative outcomes for older adults. These will be explored in more detail later in this report. This is the policy problem which this paper seeks to address: that older adults living in seniors' social housing facilities which include those with severe mental illnesses and/or addictions experience a host of negative effects as a result.

This policy problem will be investigated in the following way. Chapter 2 discusses the policy context and presents the problems which have resulted. Chapter 3 briefly describes the methodologies applied in this report. Chapters 4 and 5 analyze the policy problem through six case studies (Chapter 4) and interviews with thirteen experts and stakeholders (Chapter 5). Chapter 6 presents four policy options generated by this research. Chapter 7 explains the criteria and measures which are used to assess these options. Chapter 8 evaluates them. Chapter 9 concludes this report by recommending two interventions: funding and creating training materials for resident service coordinators, and conducting an environmental scan of the approaches currently being

made by the non-profit housing organizations which provide the bulk of British Columbia's social housing units.

Chapter 2.

Background Information

This chapter establishes the context in which the issue of housing younger persons with severe mental illnesses and/or addictions in seniors' social housing in BC takes place. It does so by determining who is responsible for the provision and administration of public housing in the province, describing which forms of seniors' social housing fall within the scope of this project, and explaining which populations are eligible to be housed there; by providing evidence that a policy change took place; by describing how the problem developed; by documenting the impacts that can result for older adults; and by discussing how seniors experience crime, the role played by fear, and whether or not persons with severe mental illnesses and/or addictions actually present any increased risk of criminal or violent behavior.

2.1. Social housing in British Columbia

The Government of British Columbia (2018) defines social housing as "…a housing development that government subsidizes and that either government or a non-profit housing partner owns and/or operates…" Responsibility for social housing falls under the jurisdiction of the Ministry of Municipal Affairs and is overseen by BC Housing, a crown corporation which works with a range of public and private stakeholders to develop, manage, and administer subsidized housing throughout the province (BC Housing, 2019a). While BC Housing is the body in charge of social housing, it directly manages just 7,800 of the approximately 76,695 units in the province (BC Housing, 2019b and 2019c).[1] The remainder is overseen by more than 550 non-profit housing providers who are supported financially by the provincial government (Mousseau, 2008).[2]

Social housing in BC is defined by the level of support which is offered to residents and the demographics to which it is available. It can be broadly described as

[1] BC Housing lists 110,465 subsidized units in the province as of March 2019. However, this includes 33,770 units of private market housing for which tenants receive financial subsidies (which are not tied to the unit). These have been excluded from the figure provided in this report.

[2] This does not include operators which are not supported by the provincial government.

taking six different forms: independent housing, supportive housing, co-operatives, assisted living, residential care, and group homes. Tenants pay rents which are either geared to their incomes or which are simply below the market rate.[3] This is determined by both the provider and the type of housing. With the exception of co-operatives, persons living in social housing are accorded the same rights, protections, and responsibilities through the *Residential Tenancy Act* as those who rent in privately-owned dwellings (Tenant Resource & Advisory Centre, 2016). While seniors live in all forms of social housing in BC, this report focuses on those which are most basic and widely available: independent seniors' housing and supportive seniors' housing. These are briefly defined below:

> **Independent Seniors' Housing:**
>
> Provides low-income seniors and younger persons with disabilities with private, subsidized units in publicly-funded facilities (BC Housing, 2019b). Some basic supports may be available, but this varies by housing provider. Of the 770 buildings which fall within the scope of this project, 741 are categorized as independent seniors' housing on the BC Housing Registry (BC Housing, 2019f).
>
> **Supportive Seniors' Housing:**
>
> Provides seniors (55+) and younger persons with disabilities or diminished ability with private, subsidized units in publicly-funded facilities. On-site support services may include daily meals, assistance with housework or laundry, social or recreational activities, and 24-hour emergency medical response services (BC Housing, 2019d). Of the 770 buildings which fall within the scope of this project, 29 are categorized as supportive seniors' housing on the BC Housing Registry (BC Housing, 2019f).

Eligibility for independent or supportive seniors' housing is determined by age (55+) or by disability. Persons with disabilities can qualify in two ways: by being the recipients of a recognized disability pension or by meeting the Canada Revenue Agency (CRA) definition of being disabled for tax purposes (BC Housing, 2019b). The latter is characterized by physical or mental impairments which have lasted, or are expected to last, for a continuous 12-month period (Canada Revenue Agency, 2020). More

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[3] Tenants of social housing whose rents are geared towards income in the buildings within the scope of this project typically spend 30% of their income on rent.

specifically, the CRA considers disabling mental conditions to be those which restrict the ability to perform routine tasks, even with access to appropriate therapy, medication, and adaptive devices (Canada Revenue Agency, 2020). These routine tasks as defined as those which require:

- Adaptive functioning: the ability to practice self-care, manage personal health and safety, initiate and respond to social interactions, and perform simple transactions;

- Memory: the ability to remember simple instructions, basic personal information or material of importance and interest; and

- Problem-solving, goal-setting, and judgement (taken together): the ability to solve problems, set and keep goals, and make appropriate decisions and judgements.

The CRA provides a number of examples of conditions which meet the above criteria, including: agoraphobic anxiety; the inability to accurately interpret surroundings; being unable to purchase groceries; unpredictable psychotic episodes; and lacking the capacity to express needs or anticipate the consequences of behavior when interacting with others (Canada Revenue Agency, 2020). While it is not explicitly mentioned in the CRA criteria, BC Housing has also considered addictions to fall under the umbrella of mental disabilities (BC Housing, 2005).

2.2. Evidence of a policy change

While there is no specific piece of legislation which can be pointed to as resulting in a policy change, there is a wealth of evidence which suggests such a change took place. In 2007, Jones noted that BC Housing had been prioritizing seniors, the homeless, and persons with mental illnesses and addictions since 2001. Indeed, these groups have been included in the handful of identified target populations in every annual report published by BC Housing from 2001 – 2019.

The focus on the homeless and those struggling with mental illnesses or addictions seems to have intensified in the mid-2000s. In 2004, the Premier's Task Force on Homelessness, Mental Illness, and Addictions was formed to help persons with those conditions secure stable, long-term housing (Patterson et al., 2008). This was followed by the 2005 Provincial Housing Strategy in which the government announced its plan to optimize existing housing stocks by prioritizing those who were in need of both

housing and support, as opposed to those who were simply low-income (Patterson et al., 2008). This is a trend which has continued to this day, with applicants to BC's limited supply of social housing currently triaged according to the following tiered criteria (BC Housing, 2019b):

1. Those facing severe risks to their health and safety, such as the homeless or persons living in shelters;

2. Those with serious medical or social needs, such as the homeless, victims of domestic abuse, or individuals living in severely inadequate housing;

3. Those whose need is moderate compared to the above;

4. Those in low need; and

5. Those applying for low-end of the market units.

The statistical data which is available also seems to support the claims made above, albeit with some qualifications. Between 2004-05[4] and 2018-19, the percentage of social housing units available to these groups occupied by seniors decreased by 11%, while those occupied by persons with disabilities or the formerly homeless increased by the same margin (BC Housing, 2005; BC Housing, 2012; BC Housing, 2019h). This is displayed below in Figure 1.

Figure 1:   Change in the percentage of social housing units occupied by seniors: 2005-06 to 2018-19

Change in the percentage of social housing units occupied by seniors: 2005-06 to 2018-19

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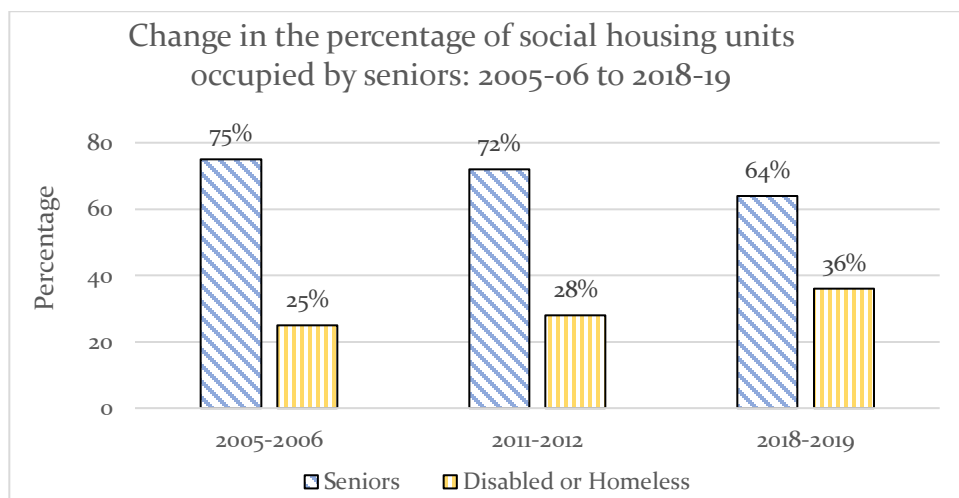
[4] This is the earliest year in which these figures were included in BC Housing's Annual Report.

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The most significant change during this time was the rapidly increasing number of homeless persons being provided with housing. Between 2006-07[5] and 2018-19, the number of homeless living in social housing grew from 2,296 to 11,204 – an increase of 388%. Over the same period, the number of seniors and persons with disabilities grew by just 33% and 10% respectively. These figures are summarized below in Table 1.

Table 1:   Number of seniors, the disabled, and the homeless in social housing: 2006-07 to 2018-19

	2006-2007	**2018-2019**	**% Increase**
Units occupied by these groups	30,647	47,758	56%
Seniors	22,863	33,612	33%
Persons with disabilities	5,488	5,905	10%
Homeless	**2,296**	**11,204**	**388%**

While these figures are suggestive, they are not a perfect metric. BC Housing's statistics also show persons with disabilities being displaced by the homeless during this time, despite the fact that persons with disabilities experiences core housing needs at a rate that is 7.8% higher than the non-disabled (BC Housing, 2019j). This is shown below in Figure 2.

Figure 2:   Percentage of social housing units occupied by seniors, persons with disabilities, and the homeless: 2005-06 to 2018-19

Percentage of social housing units occupied by seniors, persons with disabilities, and the formerly homeless: 2005-06 to 2018-19
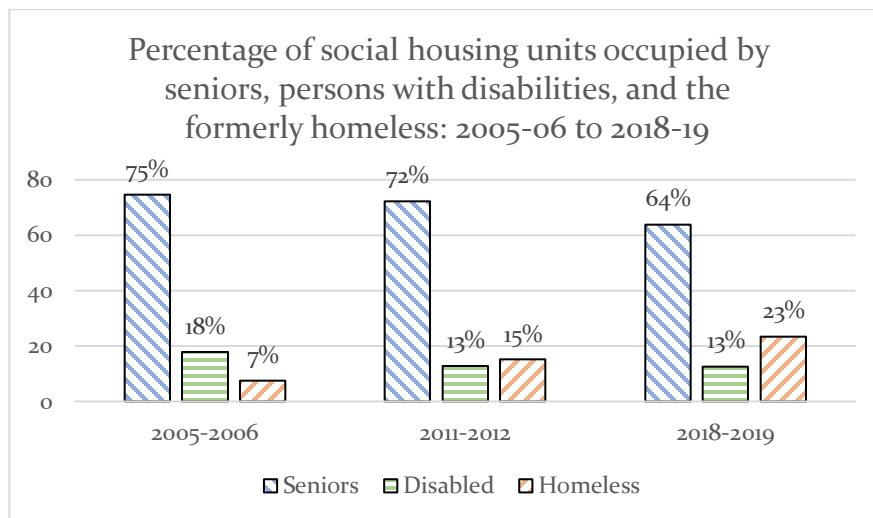
[5] BC Housing's annual reports indicate that the number of available units increased by more than 12,000 from 2005-06 to 2006-07 and then grew much more slowly thereafter. The figures from 2005-06 have been excluded as a result.

Unfortunately, precisely how these groups are defined by BC Housing is not clear and the organization was unable to provide a more detailed breakdown of the figures presented above when requested. On the surface, there is considerable overlap between the categories. Up to 25% of seniors suffer from mental illnesses and 20% of the homeless population in BC is over the age of 55 (MacCourt and Donnelly, 2012; BC Housing, 2018). The number of homeless seniors has also been rapidly increasing, growing by 284% in the Metro Vancouver region between 2009 – 2017 (SPARC BC and the United Way of the Lower Mainland, 2018). Additionally, mental illness and addictions are widespread amongst the homeless. 30-35% of homeless people in Canada suffer from a mental illness, 51-56% have a substance abuse diagnosis, and 75% of those with a mental illness have a concurrent substance abuse disorder (Mood Disorder Society of Canada, 2009). Regardless of this uncertainty, was is evident is that the percentage of social housing units occupied by seniors has decreased as the percentage occupied by the formerly homeless has risen.

This is not due to a lack of demand. From 2014-15 to 2018-19, the number of persons waitlisted for independent or supportive seniors' social housing units in BC increased from 5,347 to 7,836 while the number of applicants offered housing each year dropped from 672 to 561 (Office of the Seniors Advocate, 2019).[6] Furthermore, in 2017 BC had the highest percentage of low-income seniors of any province and between 2011 – 2016, the number of senior households in core housing in BC increased by nearly 16.8% - compared to just 1.4% for non-senior households (SPARC BC and the United Way of the Lower Mainland, 2018; CMHC, 2019).

Academic reports documenting the placement of persons with severe mental illnesses and/or addictions in seniors' social housing in BC began to emerge in the early-2000s. In 2003, Hightower et al. noted that the introduction of younger persons with those conditions into a large seniors' social housing complex in Vancouver had resulted in older tenants describing a dramatically altered environment now populated by the untreated mentally ill, sex workers, and addicts. In 2006, ter Brugge documented that 40% of those living in a 500-unit seniors' property were younger persons with mental illnesses or physical disabilities and that older tenants had become increasingly fearful of

[6] Unfortunately, a further breakdown of these figures is again unavailable and it remains uncertain how much of this increasing demand can be attributed to older adults.

the building's common areas as a result. In 2008, Spencer suggested that this process was creating unsafe living conditions for older adults and had resulted in seniors experiencing elevated levels of social isolation, emotional and psychological strain, and fears of victimization due to younger tenants and their guests engaging in disruptive and sometimes criminal behaviors such as drug-dealing.

Non-academic sources also provide evidence of a policy change. In 2007, a block watch captain wrote to BC Housing and declared the recent decision to move homeless and hard-to-house persons with mental illnesses and addictions into a large independent seniors' housing facility as dangerous, foolhardy, and "a recipe for disaster" (Private correspondence obtained by the author, 2007). Suggesting that this group had come to comprise roughly 15% of residents within in the building, the block watch captain described a broader community shocked by the subsequent rise in open substance abuse, drug dealing, harassment, and violence as well as the increasing social isolation of seniors (Private correspondence obtained by the author, 2007). Similar stories began appearing in the media. From 2010 – 2012, the Vancouver Courier published a series of articles which assigned blame for the policy change to the Ministry of Housing and described a building which had once been the exclusive domain of seniors and persons with physical disabilities as newly rife with bed bug infestations; drug and alcohol use; and seniors victimized by violence, extortion, and other forms of abuse. Similar reporting has continued to take place in the decade following the Courier's journalism.[7]

More recently, concerned community groups have mobilized to document the policy change and its impacts. In 2018, Gaudette et al. published a report on behalf of the Langley Seniors Community Action Table which criticized the decision to add younger persons with severe mental illnesses and/or addictions to a large independent seniors' housing complex for dramatically altering the residential composition and creating yet another environment in which older adults lived in fear while being exposed to a range of hazards. This study will be discussed in greater detail in section 2.4.

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[7] For more examples of media coverage of this issue in BC, see Thomas (2010, 2011, and 2012), Azpiri and Hua (2018), Ferguson (2018a, 2018b, and 2018c), and Luymes and Chan (2018).

Finally, the information presented above has been corroborated by the experts and stakeholders interviewed for this report.[8] Twelve of the thirteen participants agreed that the timeline and processes described in this paper are presented accurately. The lone voice of dissent, an expert working in housing research and policy, did acknowledge that older adults and younger persons with severe mental illnesses and/or addictions were increasingly living together in seniors' social housing facilities. However, they suggested that this was the result of an organic process based on the changing needs of different social groups, rather than any intentional act of government.

2.3. The development of the policy problem

A detailed history of the events leading to the current situation is beyond the scope of this paper, but it is nonetheless useful to the development of potential solutions to understand the social forces which led to the mingling of older adults and younger persons with severe mental illnesses and/or addictions in publicly-funded seniors' housing. Three intersecting processes have been identified as especially influential: the deinstitutionalization of the mentally ill and the failure to provide them with appropriate community supports, changing social constructions of disability, and anti-discrimination legislation.

While the focus of this capstone is British Columbia, there has been an almost complete lack of Canadian research on the policy problem. This section therefore relies on studies drawn primarily from the United States. These reports are instructive for two reasons. First, the United States shares with Canada a uniquely market-focused approach to housing, with just 5% of the population of both countries living in dwellings which are not privately-owned (Hulchanski, 2004). This stands in contrast with most other advanced western democracies, where this figure can rise to more than 30% (Hulchanski, 2004; Whitehead and Scanlon, 2007; Scanlon, Fernandez Arrigoitia, and Whitehead, 2015). Second, the processes which led to the current situation followed similar patterns in both countries – albeit ones which were in some cases separated by a number of years (Schiff et al., 2010; Niles, 2013).

[8] These will be discussed further in Chapter 5.

The deinstitutionalization of the mentally ill

The deinstitutionalization of the mentally ill which took place during the latter half of the 20th century as a result of the push for community living has been cited as a seminal factor in the changing demographics in publicly-funded seniors' housing in North America (Filinson 1993; Pynoos and Parrott 1996; Heumann, 1996; Connecticut Legislative Program Review and Investigation Committee, 2004; Perl, 2009; Read 2009; Schiff et al., 2010; Niles et al., 2013; Lindberg et al., 2015; Connecticut Department of Housing, 2018). As deinstitutionalization took place, it was anticipated that the supports required to ensure effective community integration would be provided by the government (Pynoos and Parrott, 1996; Gaudette et al., 2018). Unfortunately, this did not take place.

Read (2009) describes the total failure of the BC government to provide mentally ill persons leaving Riverview Hospital in the mid-to-late 1990s with adequate support, including housing, and documented that funding for community-based services actually decreased as deinstitutionalization occurred. This resulted in a significant rise in the number of marginalized, dependent, and poorly-supported individuals with limited financial resources and an immediate need for affordable housing (Pynoos and Parrott, 1996; Perl, 2009; Read 2009; Schiff et al., 2010; Niles et al., 2013).

Changing social constructions of disability

At the same time, conceptions of disability were expanding beyond physical and cognitive impairments to encompass less visible conditions like mental illness and addiction. This led directly to younger persons with these ailments becoming eligible for placement in publicly-funded housing originally intended for seniors and persons with physical disabilities (United States Federal Government, 1992; National Resource Centre on Homelessness and Mental Illness, 1993; Filinson, 1993; Pynoos and Parrott, 1996; Heumann, 1996; Sheehan and Stelle, 1998; Cedrone, 2001; Perl, 2009; Thomas, 2010; Lindberg et al., 2015; and Gaudette et al., 2018). It also resulted in what has been described as the current "blurring of lines between independent and supportive housing" in BC, where residents requiring different levels of psychosocial and health-related support are housed together (Gaudette et al., 2018).

Anti-discrimination legislation

Finally, the development anti-discrimination legislation which followed deinstitutionalization constrained the ability opponents to resist (United States Federal Government, 1992; Filinson, 1993; National Resource Center on Homelessness and Mental Illness, 1993; Pynoos and Parrott, 1996; Sheehan and Stelle, 1998; Cedrone, 2001; Connecticut Legislative Program Review and Investigations Committee, 2004; Perl, 2009; Lindberg et al., 2015; Connecticut Department of Housing, 2018). In the United States, the rights of disabled persons, including the mentally ill, are safeguarded at the federal level through the Fair Housing Act (1968, amended in 1988), the Rehabilitation Act (1973), and the Americans with Disabilities Act (1990). Each of which prohibits housing-related discrimination on the basis of disability (Cedrone, 2001). This allowed advocates for the homeless and mentally ill to legally challenge attempts to bar those groups from federally-funded projects intended for seniors and persons with physical disabilities (Cedrone, 2001).

Similar legislation exists in BC and Canada through the *Canada Human Rights Act* (Government of Canada, 1985) the *BC Human Rights Code* (BC Human Rights Tribunal, n.d.). The latter states that:

> Everyone has the right to be free from discrimination when renting an apartment, housing, co-op unit, or other space. Tenancy discrimination refers to poor treatment based on a personal characteristic regarding renting a space, the terms and conditions of a tenancy, or being evicted… These are the personal characteristics protected in tenancy: race, colour, ancestry, place of origin, religion, sex, gender identity or expression, sexual orientation, physical disability, mental disability, marital status, family status, age, lawful source of income.

It is therefore questionable as to whether or not younger persons with mental illnesses and/or addictions could be excluded from seniors' social housing in BC without a fundamental shift in the way in which publicly-funded housing is delivered in the province. Any attempts to do so without first providing viable alternatives for that group are likely to be met with the same legal challenges that occurred in the United States.

2.4. The impacts on seniors

Placing younger persons with severe mental illnesses and/or addictions in publicly-funded seniors' housing has been shown to have a host of negative consequences for both housing providers and older residents. While the majority of

sources for this section are again drawn from the United States, it is worth noting that at least one study of crime in Canadian public housing suggests that residents here experience higher rates of victimization than their American counterparts (DeKeseredy et al, 2003).

2.4.1. Management problems

Younger tenants with mental illnesses and/or addictions living publicly-funded seniors housing cause a disproportionate number of problems for the staff who manage and operate those buildings. In 1992, the United States General Accounting Office issued a questionnaire to 1,073 public housing authorities across the country asking them to attribute responsibility for rising number of negative incidents taking place within their seniors' facilities. Despite comprising just 8-10% of residents, younger persons with disabling mental illnesses were found to be responsible for 28-34% of all serious or moderate incidents. This included having disruptive or menacing visitors, noise violations, placing excessive demands on management, substance abuse, bizarre behaviors, and threats or violence against other residents. An additional 19% of less significant problems were also attributed to this group.

These findings were supported by subsequent research. In 1996, a longitudinal study conducted by Heumann over a three-year period following the introduction of younger persons with mental illnesses into an Illinois assisted living facility found that it resulted in endemic staff burnout. Workers reported that the need for emergency responses had tripled, that confrontations with aggressive younger residents suffering from mental illnesses became commonplace, and that relapsing addicts regularly brought problematic friends and drug dealers onto the property. Building staff also identified 34% of non-elderly residents as problematic, compared to just 6% of seniors.

In 1998, Sheehan and Stelle sent questionnaires to the 90 local housing authorities providing public housing for seniors in Connecticut and asked them to report on the number of documented negative incidents which had taken place in the previous year. This time, younger residents were found to be ten times more likely than their elderly neighbours to cause problems for management. The contrast was stark when the incidents were most serious. 69% of altercations in common areas, 76% of

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disruptive or noise-related complaints, and 80% of incidents requiring police intervention were attributed to younger persons with mental illnesses and/or addictions.

Two additional studies reinforced this data. In 2004, the Connecticut Legislative & Program Review Committee sent similar questionnaires to the now 93 local authorities which provided public housing for seniors. 23% of respondents described the level of conflict between the two groups as either significant or moderate and 71% reported experiencing at least one negative incident within the previous six months. Of the 1,103 documented incidents, 14% were classified as serious (ex. physical altercations, drug use or dealing, prostitution), 12% as inappropriate social behavior (ex. public intoxication or nudity, panhandling), and 74% as lease violations (ex. verbal altercations, excessive noise, destruction of property, disruptive guests). While only comprising 18% of the population, younger tenants were found to be responsible for 92% of the 153 serious incidents, 97% of the 131 inappropriate social behaviors, and 67% of the 819 lease violations. However, the majority of these were attributed to repeat offenders and just 6% of the population was described as problematic. In 2018, a follow-up study was conducted by the Connecticut Department of Housing to explore the 16 evictions which had taken place from three seniors housing facilities over a five-year period. 11 involved younger tenants being forced to move.

Similar evidence exists from British Columbia. An examination of police responses between 2001 – 2019 to several Lower Mainland independent seniors' social housing facilities with a total of 395 units reveals a dramatic rise in the years following integration. This is displayed below in Figure 2. Emergency calls rose from a low of 56 in 2001 to peak at 296 in 2015, an increase of 416%. While there was a slight dip in the years that followed, an average of 264 responses continued to take place annually. While this cannot be solely attributed to the introduction of younger persons with severe mental illnesses and/or addictions, it does provide further evidence of an increasingly problematic situation within those buildings.

Figure 3:   Police Responses to Select Lower Mainland Seniors Social Housing Facilities with a Total of 395 Units: 2001 - 2019

Police Responses to Select Lower Mainland Seniors Social Housing Facilities with a Total of 395 Units: 2001 - 2019
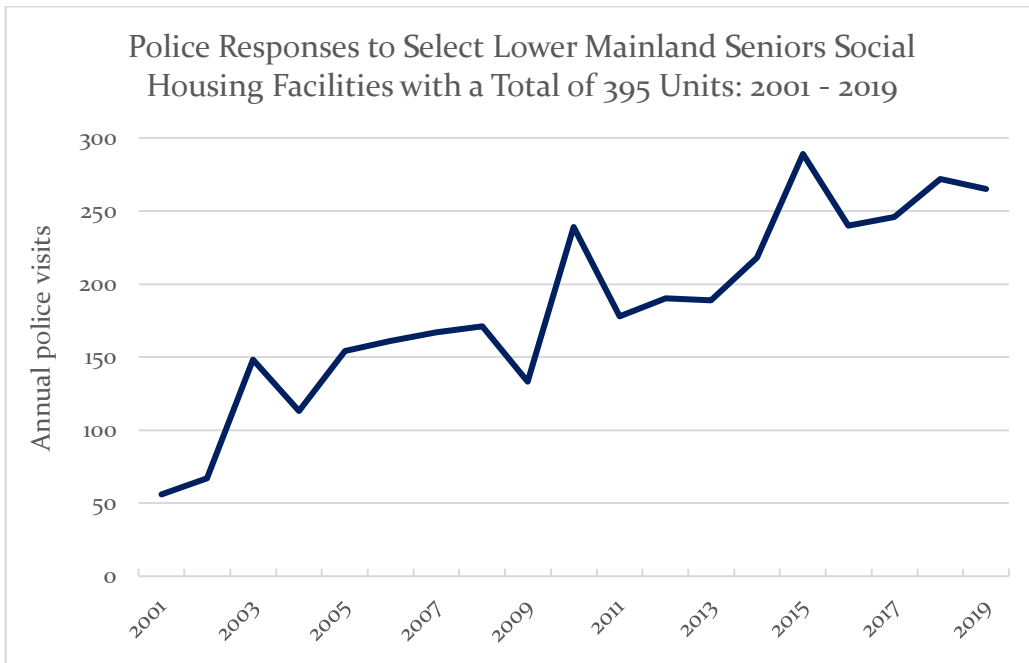
2.4.2. Impacts on seniors

Seniors experience a range of negative consequences as a result of living in the same buildings as younger persons with mental illnesses and/or addictions. Filinson (1993) was the first academic to attempt to document the severity of these outcomes. Responding to the increasing number of anecdotal stories and media accounts of seniors abused at the hands of younger tenants, Filinson surveyed 25 older adults living in facilities with large numbers of younger tenants with mental illnesses and compared their responses with a control group of 25 seniors living in buildings with few younger persons. Notably, the buildings occupied by the former were described as representing the "best-case scenario" due to the presence of on-site social workers who were available to provide support to residents. Filinson found a strong correlation between the prevalence of "disturbing" behaviors and the number of younger tenants with mental illnesses. She also quantified the impact this was having on older residents. 60% of seniors in the age-mixed buildings reported that their housing needs were not being met and 48% felt that the mentally ill did not belong in seniors' housing, compared with 8% and 0% of those in the control group respectively. This was supported by interviews in which elderly residents described themselves as afraid to leave their apartments due to

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the presence of rampant drug and alcohol use, constant noise and disruption, and episodic violence.

Heumann's previously referenced 1996 study of an Illinois assisted living facility provides a wealth of data which supports Filinson's (1993) research. Over the three-year period following the introduction of younger persons with mental illnesses and/or addictions, the number of senior tenants who disapproved of age-mixing rose from 31% to 65%, those who felt they would be safer without the younger residents grew from 37% to 71%, and those who reported that they no longer wanted to live in the building increased from 3% to 20%. This ultimately led Heumann to conclude that the two groups were fundamentally incompatible, irrespective of the amount of pre-screening that took place or the presence of support services.

Finally, Gaudette et al.'s 2018 study of a 500-unit independent seniors' social housing complex in Langley yields local data which largely reflects the above. 25% of residents living at the facility were described as younger persons with disabilities, with half of that group classified as formerly homeless or hard-to-house as a result of mental illness or addiction. 41% of the seniors surveyed reported feeling unsafe or afraid of their younger neighbours. They described being exposed to environmental hazards such as discarded needles as well as unpredictable, disruptive noise; tenants engaging in aggressive and criminal behaviors such as theft, intimidation, and assault; disinterested management which was dismissive or hostile to their concerns; and a pervasive lack of security. Participants in the study also discussed how this was impacting their lives, citing increased stress levels, usage of medication, and reliance on medical or emergency services; worsened chronic health conditions; harmful coping behaviors such as smoking; and social isolation resulting from friendly peers being replaced by younger persons unable to conform to social norms, the restricted access to common areas which followed, and the perception of their homes as too unsafe for family – especially grandchildren – to visit.

2.5. Crime as experienced by the elderly

Much has been written about the way seniors both experience crime and perceive the level of risk that they face. According to the Canadian Department of Justice (2015), roughly 10% of Canadian seniors fall victim to criminal activity each year.

Based on the most recent figures provided by Statistics Canada, this suggests that seniors in Canada experience a crime rate that is almost twice that of the general population (Statistics Canada, 2020). This stands in stark contrast with the bulk of academic literature which asserts that, despite their widespread fears, older adults are victimized at rates significantly below other demographics. However, as noted by Easton et al. (2014), this may be explained by the fact that a considerable amount of the crimes committed against seniors go unreported. Regardless of this discrepancy, the vast majority of offenses against seniors in Canada are related to property and just 1% experience violence or abuse (Statistics Canada, 2020).

While victimization of any sort has a range of negative impacts, it can be catastrophic for the small number of seniors who do suffer violence. Older adults who are injured as a result of crime experience a greater decline in their overall well-being, longer recovery times, and a higher risk of death than other groups (Lachs et al., 1998; Chu and Kraus, 2004; World Health Organization, 2018). Some evidence also exists which suggests that seniors who experience violent crime are both less likely to know their assailants and more likely to be victimized at or near their homes – a concerning result in the context of this study (Bachman, 1992).

2.6. The role of fear

Older adults suffer even when they are not victimized. Regardless of the actual risk they face, voluminous research suggests that the elderly are disproportionately afraid of crime (Normoyle and Foley, 1988; James, 1992; Smith et al., 2001; Beaulieu et al., 2003; Chadee and Ditton, 2003; Stafford et al., 2007; Ceccato and Bamzar, 2016; and Hanslmaier et al., 2018). This is true even in comparison with other vulnerable demographics which experience heightened levels of fear– including other residents of public housing (Normoyle and Foley, 1988; DeLone, 2008). This fear of victimization leads to avoidance behaviors, a lack of trust, and reduced physical activity which only serves to reinforce seniors' distorted perception of risk (Ceccato and Bamzar, 2016). It also leads to a host of other negative consequences, including increased social isolation, poorer physical and mental health, restricted lifestyles, and earlier admission into long-term care (Beaulieu et al., 2003).

However, as Hanslmaier et al. (2018) note, seniors are too often presented as a homogenous population and little attention is given to the considerable differences between groups of older adults. Along with Cozens et al. (2002), the researchers mentioned above have outlined a series of variables which influence the elderly's fear of victimization. While there is some disagreement, those factors which are generally accepted are presented below in Table 2 and apply, at least in part, to an overwhelming number of seniors living in social housing in British Columbia.

Table 2:   Variables which Influence Seniors' Fear of Crime

Variable	Impact
Poor physical/mental health or disability	Seniors who feel vulnerable as a result of a perceived inability to defend themselves, escape from potentially dangerous situations, or recover from injuries experience a greater degree of fear of crime.
The perception of local disorder	Seniors who perceive their immediate surroundings as socially disordered or incivil as a result of visible substance abuse, litter, or disrepair experience a greater degree of fear of crime.
Social isolation	Seniors who are socially isolated or who lack trust or connection with their neighbours experience a greater degree of fear of crime.
Age	Older seniors experience a greater degree of fear of crime than younger seniors.
Living alone	Seniors who live alone feel less able to defend their homes and experience a greater degree of fear of crime.
Low socioeconomic status	Seniors who are impoverished or who have low levels of education experience a greater degree of fear of crime.
Gender	Female seniors experience a greater degree of fear of crime than males.

It should be noted that while the bulk of the literature asserts that seniors do experience an elevated fear of crime, this has been challenged as overstated or oversimplified in studies by Chadee and Ditton (2003), Ditton et al. (2003), Jackson et al. (2009), and Easton (2013). In her meta-analysis of the literature, Easton (2013) suggests that the perception of the elderly as overly fearful emerged during the upheaval caused by the social movements of the 1960s and 1970s and stems from an over-reliance on quantitative research methods and an underutilization of qualitative approaches. She quotes Jackson et al. (2009) to conclude that "...the lived reality of fear of crime for older adults is one in which it is 'rarely experienced, episodic, and short-lived'".

2.7. The degree of risk posed by persons with severe mental illnesses and/or addictions

It is widely accepted that the mentally ill are victimized at rates which are many times greater than the general population, that they are more likely inflict harm upon themselves than others, and that the vast majority present no elevated risk of violent behavior (Canadian Mental Health Association, 2011 and 2020). However, a more nuanced understanding of the relationship between certain types of mental illness and criminal or violent behavior remains a matter of ongoing study and debate. Some evidence does suggest a connection between **severe** mental illness and violence – especially amongst individuals with concurrent patterns of substance use (Mood Disorder Society of Canada, 2009; Canadian Mental Health Association, 2011; Markowitz, 2011; Sabella, 2014).

In 2006, Fazel and Gramm analyzed the violent crimes committed in Sweden between 1988 – 2000 and found that the rate at which they were perpetrated by persons with severe mental illnesses was nearly 4 times greater than that of the general population. The researchers would conclude that persons with severe mental illnesses were responsible for roughly 5% of the nation's violent acts – despite comprising just 2.4% of the population (Fazel and Gramm, 2006). This is supported by the work of Markowitz (2011), who demonstrated that while only a small percentage of persons with mental illnesses were at risk of engaging in violent activities, those that did so accounted for "appreciable increases in the rates of violent and other type of crime". Both Markowitz (2011) and Sabella (2014) found that the group most disposed towards violence were those with concurrent severe mental illness and substance abuse disorders, and that they were three times more likely to do so than persons dealing with just one of those factors. Furthermore, men; persons under the age of 40; and individuals with histories of conduct disorders, violent behaviors, or involvement with the juvenile justice system were all found pose the greatest risk (Hodgins et al., 2007; Sabella, 2014).

This has a number of implications in the context of this capstone. As discussed previously, significant numbers of homeless people in Canada suffer from mental illness, addictions, or both (Mood Disorder Society of Canada, 2009). Furthermore, research has found that in the year prior to becoming homeless, 30% of those studied had been in

jail, 6% had been in a psychiatric hospital, 25% had received treatment for mental illness, and 20% had received addiction services (Mood Disorder Society of Canada, 2009). These are some of the individuals who are now being housed in what once were buildings exclusively for seniors and a small number of younger persons with physical disabilities.

Chapter 3.

Methodologies

Three research methodologies have been used in this report to analyze the issue of placing younger persons with severe mental illnesses and/or addictions in seniors' social housing. First, a literature review was conducted to provide context, trace the development of the policy problem, and demonstrate the harms which can result for older adults. Next, six case studies were performed to identify interventions which have been successfully implemented elsewhere to address the challenges can result from housing the two groups together. Finally, a series of semi-structured interviews with thirteen experts and stakeholders took place to ensure that the background and framing of the issue was accurate and to aid in the development, assessment, and recommendation of policy options.

3.1. Literature review

While the challenge of housing younger persons with severe mental illnesses and/or addictions in publicly-funded seniors' housing has received relatively little attention, particularly in Canada, a literature review was able to identify seven studies which document the development of this issue and its impacts. These reports were produced between 1992 and 2018, are drawn largely from the United States, and focus on a range of jurisdictions and outcomes. Local context is provided by a study of a seniors' social housing complex in Langley, BC as well as by statistics provided by a Lower Mainland police department. These findings are presented above in Chapter 2.

3.2. Case studies

Six case studies were conducted to identify measures taken elsewhere to improve conditions in facilities where seniors and younger persons with mental illnesses and/or addictions are housed together and to determine which interventions are most applicable to BC. This information is again drawn from the United States and explores the approaches taken at a range of levels – from state governments, to municipal

housing authorities, to individual buildings – in hopes of developing a comprehensive understanding of best practices. The results are summarized in Chapter 4.

3.3. Expert and stakeholder interviews

Thirteen experts and stakeholders from a range of disciplines, professions, and lived experiences were interviewed for this report. Participants included provincial and municipal government employees working in policy or housing-related areas; academics and other researchers; executives, administrators, or program staff from relevant non-profits; and persons who have resided in age-mixed seniors' social housing in BC.

These interviews served two primary purposes. First, they ensured that the history, context, and outcomes of housing younger persons with severe mental illnesses and/or addictions in seniors' social housing in BC were accurately described and that the issue was properly framed. Second, they aided in the development and analysis of policy options and recommendations. All interviewees were promised confidentiality in order to help them to feel comfortable speaking freely and to ensure that they did not suffer any negative repercussions as a result of their participation in this study. A thematic summary of these conversations and general description of those who took part can be found in Chapter 5.

Chapter 4.

Analysis of the Policy Problem: Case Studies

In this chapter, six case studies from the United States which highlight successful approaches to addressing the challenges associated with housing younger persons with severe mental illnesses and/or addictions in publicly-funded seniors' facilities are presented. These include interventions taken by states, municipalities, and individual buildings and, along with the literature review (Chapter 2) and expert and stakeholder interviews (Chapter 5), form the basis for the policy options presented in Chapter 8. A summary of those interventions deemed to be effective is presented below in Table 3.

Table 3:   Summary of sccessful interventions identified in case studies

	State of Massachusetts	Tyrol Plaza, Anaheim, California	State of Connecticut	La Salle County, Illinois	St. Paul, Minnesota	Rockford, Illinois
Resident service coordinators	x	x	x	x	x	x
Special training for staff				x		
Education for residents			x		x	x
Local partnerships			x	x		
Access controls						x
Security guards						x
Limiting number younger tenants	x					
Enhanced screening	x		x	x	x	x
Stronger lease enforcement	x		x			

Notably, each case study demonstrates the effectiveness of resident service coordinators as effective, while all but one jurisdiction utilized enhanced screening processes such as reference and criminal record checks. The latter are currently available to housing providers in BC. Additionally, protection-oriented measures such as security guards or access controls were adopted by only one site each, while other

approaches such as limiting the number of younger residents or the rapid eviction of problematic tenants through stronger lease enforcement are not currently possible in BC due to anti-discrimination legislation and the *Residential Tenancy Act.*

4.1. The State of Massachusetts

In 1995, the Massachusetts state government responded to increasing concerns surrounding the mixing of the elderly and younger persons with mental illnesses in publicly-funded seniors' housing with a multi-pronged intervention. To address the fact that younger residents with disabilities had come to outnumber older adults in facilities originally intended for the elderly, the state capped the number of non-seniors at 13.5% (Connecticut Legislative Program Review and Investigation Committee, 2004). However, younger persons already living in seniors' housing would not be evicted to meet this target and exceptions were allowed when vacancies would otherwise go unfilled (Connecticut Legislative Program Review and Investigation Committee, 2004). This ratio was established through in-depth consultations with advocacy groups representing both populations, elected officials, and staff from the Department of Housing and Community Development (Connecticut Legislative Program Review and Investigation Committee, 2004). Current and prospective younger tenants with disabilities were also encouraged to seek alternative accommodations through the provision of private-market rent subsidies and the creation of a state-wide registry of all accessible units available from both public and private sources (Connecticut Legislative Program Review and Investigation Committee, 2004).

The state government also focused on improving conditions within facilities. Funding was provided for the hiring of resident service coordinators who helped tenants access social and healthcare services, mediate conflicts, enforce lease conditions, and ensure that the quality of life for other residents was not negatively impacted by their problematic neighbours (Connecticut Legislative Program Review and Investigation Committee, 2004; Stockard, 2014). Housing authorities were also granted greater screening powers. This included access to the state criminal database and the removal of substance abuse as a qualifying disability for state-funded seniors' housing (Connecticut Legislative Program Review and Investigation Committee, 2004). Finally, an expedited eviction process was put in place to remove residents who were found to be responsible for causing physical harm to other tenants, in possession of illegal

firearms, or engaging in criminal activity which threatened the well-being of others (Connecticut Legislative Program Review and Investigation Committee, 2004). These are the most robust protection-oriented approaches found in these case studies.

While there is limited evaluative information available on the impact of these policies, a 2002 report conducted by the University of Massachusetts concluded that the resident service coordinators had eased the level of conflict between the two groups, reduced evictions, ensured that residents were better able to access the services they required, and allowed housing authority staff to focus more on day-to-day operations (Connecticut Legislative Program Review and Investigation Committee, 2004). Furthermore, the cap on the number of younger tenants was found to have slowed and, in some cases, reversed their presence in publicly-funded seniors' housing (Connecticut Legislative Program Review and Investigation Committee, 2004).

4.2. Tyrol Plaza Seniors Apartments, Anaheim, California

Tyrol Plaza is a 60-unit age-mixed supportive housing facility for low-income seniors, persons with disabilities, and those who are homeless or at risk of becoming homeless. Fully half of the suites are reserved for individuals in the latter category (Shelter Partnership Inc., 2009). In 2009, 26% of these residents had mental disabilities and an additional 26% had both physical and mental disabilities. The prevalence of concurrent substance abuse disorders is unknown as applicants were not required to disclose this information and staff declined to provide an estimation for researchers (Shelter Partnership Inc., 2009). Based on the literature reviewed for this report, it could be reasonably assumed that this tenant composition would lead to significant challenges; however, this does not appear to be the case.

While building staff reported that the formerly homeless residents initially required more attention and resources than other tenants, over the long-term they found the differences between the groups to be negligible (Shelter Partnership Inc., 2009). The most commonly cited issues – unauthorized visitors, cluttered suites, smoking, and the noise-related disturbance of other tenants – were attributed to an unfamiliarity with apartment living and ignorance of how certain behaviors may affect others, rather than any sort of fundamental incompatibility between different groups (Shelter Partnership Inc., 2009). Occasionally, more serious issues such as substance abuse, the

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unsupervised cessation of medication, and residents inviting homeless friends to live with them were also found to occur, but site staff reported that only a handful of such incidents took place each year and described them as exceptions rather than the norm (Shelter Partnership Inc., 2009).

Tenants from all groups were found to experience similarly high levels of satisfaction with their housing. The atmosphere within the building was described as supportive and congenial, other residents were perceived to be "good neighbours", and appreciation was expressed for the level of care and attention provided by staff (Shelter Partnership Inc., 2009). Compared to the other examples presented in this chapter, the level of reported conflict within Tyrol Plaza was minimal.

One potential explanation for the relative harmony within the building is the high level of staffing in place to provide robust supports to residents and help ensure their tenancies are successful. Tyrol Plaza provides funding for a full-time resident service coordinator who is responsible for delivering a range of supports, including case management, assistance with meals, referrals and advocacy, and life-skills training (Shelter Partnership Inc., 2009). They are supported by one part-time case worker and one part-time caregiver who assist the most high-needs tenants from the homeless population (Shelter Partnership Inc., 2009). Property management is provided by a full-time manager who lives on-site as well as a part-time maintenance person and a part-time housekeeper (Shelter Partnership Inc., 2009). The impact of the resident service coordinator in particular has been cited as vital to the successful integration of tenants, with case management, resident engagement, assistance with meals, referrals, life-skills training, and advocacy all reported as critical by other staff members (Shelter Partnership Inc., 2009).

4.3. New recommendations from Connecticut

In 2018, the Connecticut Department of Housing released their final report on the challenges associated with housing younger persons with mental illnesses in state-funded seniors' buildings. Published 14 years after the 2004 study cited frequently in this paper, it highlighted the continued and growing need for housing amongst both groups (while noting that the needs of younger persons were increasing more rapidly) and offered updated policy recommendations. Arguing against the practicality of other

alternatives due to concerns about equity, the limited supply of affordable housing, and the financial viability of existing projects, the Department of Housing suggested a series of enhanced protections and supports for residents as the means through which to improve conditions for both groups. This included better screening of prospective tenants; stronger lease enforcement and more effective evictions; funding resident service coordinators and providing them with training materials; increased cooperation with social service agencies; and education for tenants on issues related to aging, disability, and mental illness.

4.4. La Salle County, Illinois

This is the first of three case studies taken from the 1993 *Creating Community* report produced by the National Resource Center on Homelessness and Mental Illness for the United States Department of Housing and Urban Development (HUD). At that time, the La Salle County housing authority served a rural population of just over 100,000. They addressed the problems created by age-mixing in seniors' housing in three ways: by improving their screening process, by providing specialized training to staff, and by increasing the level of support available to tenants.

The responsibility for the screening of potential residents was transferred to mental health professionals who were better able to ensure that applicants did not pose a threat to themselves or to others, determine if they would be able to abide by their lease conditions, and identify their level of functioning and the amount of support they would require. This process involved both criminal record and reference checks.[9]

To better manage their responsibilities, staff received training in stress management; communication skills; and on issues related to aging, mental illness, and addiction. Education on the latter was provided through a partnership with a local mental health provider and was found to be especially valuable, with staff reporting that it had allowed them to be more effective in their roles.

Tenants also received extra support. Resident service coordinators were hired to oversee conditions within buildings and deliver case management, make referrals to

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[9] Homeless residents without landlord references were able to use those provided by shelter staff.

social services, lead individual and group therapy sessions, and assist management during inspections. They also helped develop a sense of community amongst tenants by supporting the formation of resident councils and by leading educational sessions on issues related to mental health – something which the elderly reported as having eased their fears of the younger residents. Finally, specific supports for those suffering from psychological conditions were also put in place, with a local mental health centre offering off-site treatment as well as 24-hour crisis intervention.

4.5. St. Paul, Minnesota

The second case study drawn from *Creating Community* (1993), in 1993 the St. Paul Public Housing Agency operated 2,620 units across 16 buildings. Approximately 46% of residents in seniors' buildings were younger tenants with disabilities – roughly 28% of whom were suffering from severe mental illnesses. The challenges this posed led to the creation or redefinition of a number of staff roles.

A program service manager position was created to plan programming, secure additional funding for support services, and build relationships with community-based organizations with a focus on mental health. This would ultimately result in representatives of those agencies joining the housing authority board as well as robust on-and-off-site services being made available to residents with severe psychological disorders. The program service manager was supported by three human services coordinators who provided tenants with needs assessments, crisis intervention, and referrals or advocacy. The coordinators also helped to educate residents from both groups on issues related to aging and mental illness, promoted community-building activities, investigated reports of lease violations, and implemented new schedules which ensured they were on-site during evenings. This led to a reduction in reported problems and an increase in the number of residents who said that they felt safe in their buildings.

Additional protections were also put in place. Applicants were screened on their ability to pay rent, maintain their units, and comply with lease requirements. This included credit checks; references from prior landlords or shelter staff, social workers, or other care providers; and a criminal record check. To ensure continued support for the

most challenging tenants, case managers making referrals were asked to provide assurance that they would continue to assist their clients after they were housed.

4.6. Rockford, Illinois

The final case study taken from *Creating Community* (1993), in 1993 the Rockford housing authority addressed the increasing prevalence of mental health issues in its buildings and the subsequent flight of seniors by piloting a series of improvements to their largest facility – a high rise building of 418 units that contained nearly half of the city's publicly-funded housing for seniors.

First, a partnership was established with a local non-profit organization with a focus on mental health to provide services for tenants suffering from mental illnesses. State funding from the Department of Mental Health was then secured to hire a case manager and other support staff to provided tenants with supervision, skills training, educational workshops on mental health, social activities, advocacy and referrals, and crisis intervention. These workers were supported by two resident assistants and a maintenance worker who lived on-site and provided after-hours coverage.

Building renovations also played an important role in both improving security and further enhancing the supports available to tenants. Card-controlled doors were put into place to restrict access, a video monitoring system was installed, and overnight guards were hired. Space was also created for an on-site meal program, a healthcare clinic, a day treatment centre, and an office in which a full-time nurse case manager could provide health screenings and referrals.

The final improvement was the prioritization of the involvement of tenants in building operations and management. The resident council was given their own office and equipment which they used to print a monthly newsletter; arrange outings, parties, and other activities; and operate a resource centre. The ultimate result was an environment in which younger persons with mental illnesses reported feeling welcome and part of a community.

Chapter 5.

Analysis of the Policy Problem: Expert and Stakeholder Interviews

5.1. Overview and rationale

A series of twelve expert and stakeholder interviews with a total of thirteen participants were conducted as part of this study. These took place between August 2019 and February 2020, with most occurring as semi-structured, one-on-one conversations in person or over the phone. Two involved joint interviews with two participants while one took place through email due to time constraints and scheduling issues.

Interviews were included as a research methodology for three reasons. First, to ensure that the background information and the framing of the policy problem were presented accurately. This was especially necessary given the relative lack of BC or Canada-specific research on this subject. Second, to identify and explore common themes. This resulted in a more well-rounded understanding of the policy problem, the way it is perceived, and its impacts. Third, to aid in the development and assessment of policy options. This allowed for a more fulsome evaluation of the options and made certain that those which resulted were seen as suitable for BC.

5.2. Interview process and participants

A cross-section of relevant experts and stakeholders was sought for this capstone report. Interview requests were sent out to 20 different individuals or organizations representing a range of experiences, expertise, and perspectives. This included academics and other researchers; staff from BC Housing and non-profit housing providers; advocates for seniors, persons with mental illnesses, and the homeless; non-profit executives and staff from organizations which provide services to seniors and persons with disabilities; and older adults who have lived experience in age-mixed seniors' social housing in BC (including those who also experience disabling mental illnesses). Eight requests did not receive a response or did not proceed beyond

preliminary discussions and twelve interviews with thirteen participants ultimately occurred. Any identifying details of interview participants have been omitted, but a general summary of those who took part is presented below in Table 4.

Table 4:   Backgrounds of Expert and Stakeholder Interview Participants

Interviewee
Housing policy researcher 1
Housing policy researcher 2
Housing policy researcher 3
Social policy planner
Housing administrator with a focus on community engagement and tenant support
Researcher who has studied the impacts of housing mentally ill and/or addicted younger persons in publicly-funded seniors housing
Academic with expertise in gerontology, homelessness, and housing-first policies
Executive with a seniors-focused organization and a background in mental health
Professional with extensive experience providing support to persons with disabilities – including those with severe mental illnesses and addictions
Gerontological social service worker with clients living in age-mixed seniors' social housing
Resident of age-mixed seniors' social housing in BC 1
Resident of age-mixed seniors' social housing in BC 2
Resident of age-mixed seniors' social housing in BC 3

5.3. Thematic analysis

The background information and framing of the policy issue presented in this paper are accurate

All but one interviewee agreed that the policy issue and its development have been described and presented accurately in this report. The interviewee who disagreed acknowledged that the mixing of younger persons with mental illnesses and/or addictions with older adults was taking place in seniors social housing, but suggested that this was the result of an organic process and the needs of these groups, rather than any intentional policy choice by the provincial government. Three others asserted that the process of moving the homeless and hard-to-house into seniors' buildings was accelerated during the lead up to the 2010 Olympics – this included two individuals with lived experience in age-mixed seniors' social housing as well as a service provider who frequently made visits to these facilities. This claim was unable to be verified.

More BC-specific research is needed

Every interviewee expressed concern or surprise about the lack of attention paid to this issue in BC, including academics and researchers working in directly-related areas. While all were aware that housing younger persons with severe mental illnesses and/or additions in seniors' social housing had taken place and was potentially problematic, none felt that they fully understood the issue or the challenges it posed. Those with lived experience in social housing also reported that they felt ignored and excluded by building managers, researchers, and decision-makers.

Social housing in BC is complex and shapes the potential solutions to the policy problem

Most interviewees felt that the diffuse structure of the social housing sector in BC as well as the general lack of alternative forms of affordable housing due to limited supply both constrain the development of potential solutions to the policy problem. Several interviewees with direct knowledge stated that BC Housing's relationship with the non-profit organizations that provide the bulk of the province's social housing is complicated, only semi-hierarchical, and intentionally hands-off. As a result, the services available to tenants, as well as the manner and skill with which they are delivered, vary considerably while collaboration between different groups can be limited or non-existent. This leads to an uneven experience for residents, both across different providers and even between buildings operated by the same organization. Furthermore, without a radical and evidently undesired transformation in the relationship between BC Housing and its partner organizations, policy interventions can only incentive change. It cannot be mandated.

The current situation is problematic

All interviewees were in agreement that the current situation is problematic for both older adults living in seniors' social housing as well as the younger persons housed with them. While there was a general consensus that more supports for residents and better training for staff are needed, there was a degree of disagreement regarding the fundamental ability of younger persons with severe mental illnesses and/or addictions and seniors to live together harmoniously. Those most skeptical of this were in the minority, but notably included both seniors with lived experience in age-mixed social

housing and their advocates. However, all agreed that the current lack of alternatives means that complete segregation is not currently a feasible solution.

There is widespread concern for the well-being of younger persons with severe mental illnesses and/or addictions

Every person interviewed for this capstone expressed concern for the well-being of younger persons suffering from severe mental illnesses or addictions and were in near-complete agreement that no policy options should be proposed which hold the potential to negatively impact this group. While some questioned the suitability of housing the them with seniors, most felt that any form of segregation, even within buildings, was unacceptable and all were worried about increasing the already considerable stigma and marginalization experienced by those experiencing mental illnesses. The ubiquity of this sentiment and the conviction with which it was expressed were striking, though it is unclear to what degree – if any – concerns about political correctness coloured these opinions.

Seniors and persons with mental illnesses or addictions should not be viewed as discrete groups

Many interviewees stressed that there is considerable overlap between the two groups and that they cannot be viewed as entirely separate from one another. One interviewee with extensive experience providing support to persons with disabilities also challenged the perception of younger persons with mental illnesses as violent predators and seniors as helpless victims as inaccurate, unrealistic, and inhibitive of problem-solving.

The problems described by seniors and their advocates mirrored those described in the literature[10]

Seniors with lived experience in social housing, those who have researched the issue of age-mixing in social housing in BC, and those who provide support services to older adults all reported that elderly tenants of these facilities live in fear; experience social isolation; occupy buildings in which drug use, sex work, and problematic

[10] See Appendix A for a detailed description of one interviewee's experience living in an independent seniors social housing facility in BC.

behaviors are widespread; and are exposed threats, property crime, intimidation, and violence as a result of the current situation. Their descriptions of this are largely reflective of those described in the broader literature surrounding this subject which was presented in Chapter 2.

Chapter 6.

Policy Options

This chapter offers four policy options which have been informed by the research presented above. These have been shaped by the structure of BC's social housing system, the philosophical approach that no undue harm should come to younger persons with severe mental illnesses and/or addictions, and the services and supports which are already in place (such as the prescreening of applicants for problematic criminal histories). As a result, there are no options which suggest removing or banning the younger group from seniors' social housing as there are no viable alternatives and, regardless, doing so would likely be considered illegal under the *Residential Tenancy Act* for the reasons previously discussed. Furthermore, because of diffuse nature of social housing in the province and the intentionally hands-off approach taken by BC Housing in their relationships with non-profit housing providers, all options are incentive-based. It was evident from the interviews conducted for this report that there is no desire for change in the relationship between BC Housing and its partners – therefore, none is proposed.

6.1. Policy option 1: Provide funding for resident service coordinators

Providing funding for resident service coordinators is likely to improve conditions for both elderly and younger residents of seniors' social housing. Indeed, they have proven uniquely successful in doing so. While some tenant support workers are currently available to those living in facilities which are directly managed by BC Housing, only 35% of non-profit housing providers have staff in similar roles (BC Non-Profit Housing Association, 2018). Even when these positions do exist, they can be ineffectual due to the heavy workloads which result from a lack of funding. One interviewee noted that a non-profit housing provider which manages more than 1,000 affordable units had just two workers available to provide support to tenants. This was not a full-time role for either person and their work was described as reactive and crisis-oriented. Providing funding for non-profit housing associations to hire these workers in sufficient numbers will ensure a consistency of service for all persons living in seniors' social housing, will

help to improve conditions within facilities, and will lead to a higher quality of life for some of the most vulnerable and marginalized populations in the province.

This would be implemented through the creation of a new funding stream which would be offered by BC Housing to non-profit operators. Once a grant proposal was approved, these organizations would receive annual, recurring grants which would cover the entirety of the costs of properly staffing these positions. Educational resources would also be created in support of these roles to ensure a baseline level of competency.

6.2. Policy option 2: Provide funding for after-hours security coverage

An examination of the BC Non-Profit Housing Association Sector Salary and Benefits Survey (2018) suggests that there are no security guards currently employed by non-profit social housing providers in BC. Creating funding for security coverage during the hours when staff are not on site is one of the best practices identified through the research conducted for this report and offers the promise of improved safety through the monitoring of overnight activities and the ability to react swiftly to any disturbances or conflicts – especially those which do not require immediate police responses.

This would be implemented in much the same way as policy option 1. The provincial government would create a new grant through which BC Housing would provide funding to applicants from the non-profit social housing sector. They would then receive the financial support needed to hire after-hours security guards for their buildings. Educational resources targeted at improving the guard's awareness of mental health issues would also be created.

6.3. Policy option 3: Introduce segregated floors and access controls within buildings

Researchers such as Heumann (1996) and Cedrone (2001), along with two of the individuals interviewed for this report (including one resident of seniors' social housing in BC), have argued that there is a fundamental incompatibility between older adults and younger persons with severe mental illnesses and/or addictions. While this is

debatable, it is clear that serious problems have resulted from housing the populations together.

The most direct approach to addressing these problems is to separate the two groups. While the current lack of alternative affordable housing options in BC and the constraints of the *Residential Tenancy Act* means that outright segregation is not possible, other jurisdictions such as Rockford, Illinois have used access-controlled doors within buildings to limit the opportunities for clashes between residents. The same can be done in BC. The risk to seniors can be further reduced by housing them on separate floors.

Implementation of this option would take the same form as the other policy options – through a grant-based system in which BC Housing would make funding available to non-profit organizations to pay for the required renovations.

6.4. Policy option 4: Status quo plus additional research and pilot projects

The bulk of the research upon which this capstone is based comes from just a handful of studies. Some are decades-old and all but one focus on areas outside of BC. As a result, the most prudent course of action may be to engage in additional intensive and BC-focused research in order to better inform the development and recommendation of policy options. This would involve partnering with a university or other research-focused organization with expertise in the subject matter to conduct a two-phased project. First, as encouraged by a number of those interviewed for this report, a robust environmental scan would be performed to identify and evaluate the efforts which are currently being made by the various housing providers across the province. It has been suggested that some of the initiatives which have been independently employed have been extremely effective, but are largely unknown outside of the organizations which offer them. Following this, pilot projects for any of the best practices highlighted in this paper which had not been attempted would be trialed and evaluated. Those interventions then deemed to be most effective, appropriate for BC, and scalable could then be offered to providers throughout the province through funding streams in much the same way as the other policy options presented above.

Chapter 7.

Evaluative Criteria and Measures

The policy options presented in Chapter 6 will be assessed according to the following criteria: security and protection for seniors, fairness and equity for younger persons with severe mental illnesses and/or addictions, budgetary considerations, administrative complexity, and stakeholder acceptance. These are described in detail below and are summarized in Table 4. The first two criteria have been deemed most important and are the most nuanced in the context of this study. As a result, they have been given a weight which is twice that of the others.

7.1. Definitions

Security and Protection

This criterion evaluates the degree of security and protection that the policy option offers to elderly residents living with younger persons with severe mental illnesses and/or addictions in seniors' social housing. It will be assessed using two distinct measures which are described below, the combination of which will result a double-weighting for this category. Following implementation, these metrics can be measured through both qualitative and quantitative research.

The first measure is a projection of the likelihood of a reduction in the levels of victimization or the fear of victimization reported by seniors. As has been demonstrated, both are important to the health and well-being of older adults and their subjective experiences need to be considered. A higher score will be given to those options which are expected to make the greatest impact in this area.

Second, it will project the anticipated change in the number of police responses to seniors' social housing facilities in which age-mixing takes place. A higher score will be given to those options which are expected to result in the greatest decrease in policy responses.

Equity and Fairness

  This criterion analyzes the impact of the policy option on younger residents of seniors' social housing who are mentally ill and/or addicted. While the focus of this report is on the well-being of vulnerable seniors, persons with severe mental illnesses and addictions are amongst the most marginalized groups in Canadian society and they are deserving of the same care, compassion, and support as any other group. It is the position of this capstone that it is unethical to unfairly burden them with negative outcomes in response to a situation over which they have little to no control and that this must be considered when evaluating policy options. As in the case of the preceding criterion, this will be evaluated through two measures which again combine for a weighting twice that of most others.

  First, the expected change in the amount of housing available to younger persons with severe mental illnesses and/or addiction will be assessed. A higher score will be given to those option which result in little to no decrease.

  Second, the change in the level of stigma faced by younger persons with mental illnesses and/or addictions will also be estimated. A higher score will be given to those options which will result in the no charge or a decrease in this area.

Budgetary Considerations

  This criterion assesses the total costs of the policy option. While lower costs are obviously preferred, they are secondary to effectiveness and therefore this criterion has not been given any additional weight. A higher score will be given to those options which are less expensive, more economically efficient, and require the fewest resources.

Administrative Complexity

  This criterion explores the additional administrative demands placed on the provincial government (including BC Housing) by the policy option. This includes the likelihood that a new institutional body would need to be created, that additional administrative staff would need to be hired, or that significantly increased demands would be placed on existing public servants through the need for greater coordination or collaboration. Those policy options which require less administrative resources will be scored higher.

Stakeholder Acceptance

This criterion measures the degree of support for the policy option by relevant experts and stakeholders. This includes those who advocate for seniors and persons with mental illnesses and/or addictions, and will be based largely off the feedback from those who were interviewed for this report. This can be used to reasonably estimate the more widespread level of support for a policy option. Those policies which are more likely to be supported by supporters of both groups will receive a higher score.

7.2. Criteria and measures matrix

Table 5:   Criteria and Measures Matrix

Societal Objectives			
Objective	**Criteria**	**Measure(s)**	**Scoring (higher is better)**
Security and Protection (weighted x2)	The perceived and real increase or decrease in the safety of older adults living in age-mixed, seniors' social housing.	*Measure 1:* The change in the percentage of seniors who report victimization or a fear of victimization. Following implementation, this can be measured through qualitative surveys of residents.	*High: 3* A reduction of >50% in the number of seniors who report victimization or a fear of victimization. *Medium: 2* A reduction of 10-50% in the number of seniors who report victimization or a fear of victimization. *Low: 1* A reduction of 0-9% in the number of seniors who report victimization or a fear of victimization.
		Measure 2: The change in the number of police responses to relevant social housing facilities. This can be measured through the statistics kept by municipal police departments and the RCMP.	*High: 3* A reduction of >50% in the number of police responses. *Medium: 2* A reduction of 10-50% in the number of police responses. *Low: 1* A reduction of 0-9% in the number of police responses.

Societal Objectives			
Objective	**Criteria**	**Measure(s)**	**Scoring (higher is better)**
Equity and Fairness (weighted x2)	The impacts on younger persons with severe mental illnesses and/or addictions living in seniors' social housing in BC.	*Measure 1:* The change in the amount of housing available to younger persons with severe mental illnesses and/or addictions.	*High: 3* No change or an increase in the housing available to younger persons with severe mental illnesses and/or addictions *Medium: 2* A reduction of 1-20% in the housing available to available to younger persons with severe mental illnesses and/or addictions. *Low: 1* A reduction of >20% in the housing available to younger persons with severe mental illnesses and/or addictions
		Measure 2: The change in the level of stigma faced by younger persons with severe mental illnesses and/or addictions living in social housing.	*High: 3* A decrease in the level of stigma faced by younger persons with severe mental illnesses and/or addictions. *Medium: 2* No change in the level of stigma faced by younger persons with severe mental illnesses and/or addictions. *Low: 1* An increase in the level of stigma faced by younger persons with severe mental illnesses and/or addictions.
Budgetary Considerations	The projected up-front and operating costs.	The expected dollar cost.	*High: 3* Anticipated costs of <$10 million. *Medium: 2* Anticipated costs of $10-30 million. *Low: 1* Anticipated costs of >$30 million.
Administrative Complexity	The increased administrative demands placed on government and public servants.	The need to create a new department, hire additional administrative staff, or significantly increase	*High: 3* No administrative changes are required. *Medium: 2* One of the examples in the preceding column is required. *Low: 1*

Societal Objectives			
Objective	**Criteria**	**Measure(s)**	**Scoring (higher is better)**
		coordination / collaboration between existing roles.	Two or more of the examples of the preceding column are required.
Stakeholder Acceptance	The level of support from stakeholder groups representing both seniors and younger persons with mental illnesses or addictions.	The support indicated by persons interviewed for this report as well as the projected level of support from relevant community groups.	*High: 3* >70% support the option. *Medium:2* 50-70% support the option. *Low: 1* <50% support the option.

Chapter 8.

Evaluation of Policy Options

8.1. Evaluation of policy option 1: Provide funding for resident service coordinator positions

Security and Protection:

> *Measure 1 (change in the number of seniors reporting victimization or the fear of victimization):* **High**

> *Measure 2 (change in the number of police responses to age-mixed seniors' social housing facilities):* **High**

Resident services coordinators improve conditions within public facilities housing seniors and younger persons with mental illnesses and/or addictions in four key ways. First, they ensure that residents have ready access to the supports they require. This is done by providing information and referrals to community-based organizations, advocating on behalf of residents, and forming relationships with agencies to bring more services on-site (National Resource Center on Homelessness and Mental Illness, 1993; Connecticut Legislative & Program Review Committee, 2004; Shelter Partnership, 2009; Stockard, 2014). Second, they aid in the development of a sense of community amongst residents. This is accomplished in a variety of ways, such as educating both groups on issues related to mental illness or aging, scheduling special events where tenants can meet and interact with one another, supporting the formation and operation of resident service councils, or encouraging volunteerism for those who want to take a more active role in their buildings (National Resource Center on Homelessness and Mental Illness, 1993; Connecticut Legislative & Program Review Committee, 2004; Shelter Partnership, 2009; Stockard, 2014). Third, they allow building managers and other staff to spend more time and energy on day-to-day operations. While this has little immediate impact on residents, it ensures that their buildings are well-operated, in good repair, and that lease-related issues are promptly and effectively addressed when it becomes necessary to do so (National Resource Center on Homelessness and Mental Illness, 1993; Connecticut Legislative & Program Review Committee, 2004; Shelter

Partnership, 2009; Stockard, 2014). Finally, they are able to proactively mitigate conflicts between residents before they develop into crisis situations that could potentially result in evictions (National Resource Center on Homelessness and Mental Illness, 1993; Connecticut Legislative & Program Review Committee, 2004; Shelter Partnership, 2009; Stockard, 2014).

Staffing these positions has been shown to result in reduced levels of fear and increased feelings of security for older adults, the successful integration of the mentally ill or homeless, and a decrease in negative incidents (National Resource Center on Homelessness and Mental Illness, 1993; Connecticut Legislative & Program Review Committee, 2004; Shelter Partnership, 2009; Stockard, 2014). This is true even for buildings which provide housing for persons with histories of violence or addictions – with proper support, significant numbers are able to successfully move into and remain in independent subsidized housing (Patterson et al., 2008).

There is also recent evidence of success from a Canadian jurisdiction. An evaluation of a year-long pilot project in the Manitoulin-Sudbury District in Ontario found that the hiring of a resident support worker for tenants with mental illnesses living in a four-building complex had led to a number of improvements. These included a 66% decrease in the number of paramedic calls; a 20-56% reduction in police responses to three of the buildings (the fourth building saw an increase of 13%); and an 85% drop in the number of incidents involving emergency medical and police services, hospitalization, the use of crisis lines, the initiation of eviction processes, and outcomes of homelessness for residents (Canadian Mental Health Association Sudbury/Manitoulin, 2017). This option has accordingly been awarded the highest possible score for both measures.

Equity and Fairness

> *Measure 1 (change in the amount of housing available to younger persons with severe mental illnesses and/or addictions):* **High**

> *Measure 2 (change in the level of stigma experienced by younger persons with mental illnesses and/or addictions):* **High**

Funding resident service coordinators will ensure that all tenants living in seniors social housing in BC have access to the same services and supports, regardless of their providers or the specific facility in which they are housed. Within buildings, the community-building initiatives of resident support coordinators has been found to reduce the level of stigma faced by younger persons with mental illnesses and/or addictions while also easing the fears of older adults (National Resource Center on Homelessness and Mental Illness, 1993). This is likely to create an environment in which the elderly feel more comfortable and less afraid of their younger neighbours, while younger persons with severe mental illnesses and/or addictions feel more welcome and accepted (National Resource Center on Homelessness and Mental Illness, 1993). Based on the above, this option has been awarded the highest possible score in both measures.

Budgetary Considerations: Low

This is the most expensive of the four policy options. The average annual salary of a tenant support worker with a BC non-profit housing provider in 2018 was $42,779.56 (BC Non-Profit Housing Association, 2018). Factoring in a 2% cost-of-living increase for both 2019 and 2020, the average salary increases to $44,507.88. When benefits are included, this number rises further to $48,660.[11]

It is challenging to identify the ideal caseload for these workers and to determine the number of positions which will need to be funded for this option to be successful. Benjaminsen (2014) recommends a caseload of no more than 8 clients for workers providing support to formerly homeless individuals suffering from mental illnesses; King (2004) suggests 30; and a recent study of core social service providers (including housing support workers) in Ontario found they carried an average caseload of 62 (BMA Management Consulting, n.d.). In the Manitolin-Sudbury study referenced above, the resident support worker provided intensive case management for 45 tenants while also supporting an additional 171 not-uniquely-identified residents with briefer, more limited services (Canadian Mental Health Association Sudbury/Manitoulin, 2017). Additionally, several of the case studies presented in Chapter 4 suggest that just a handful of workers

[11] Benefits were estimated using the University of British Columbia Benefits Cost Calculator for Employers which can be accessed at:
http://payrollintranet.ubc.ca/calculators/benefitscostcalculator.htm.

may be required, even for housing authorities which provide shelter to thousands of residents.

Obviously, not all tenants of seniors' social housing will require support, let alone active case management, and studies suggest that only a small percentage of residents are actually problematic (Heumann, 1996; Connecticut Legislative & Program Review Committee, 2004). It therefore seems reasonable to assume that a ratio of one resident service coordinator for every building with 100 or fewer tenants, with another coordinator added for each additional 100 tenants within a facility, should be sufficient. Based on the figures provided by the BC Housing Registry, this would require funding for a total of 839 workers. This is likely an overestimate of the need as 35% of operators already have similar staff in place (BC Non-Profit Housing Association, 2018). Furthermore, there are a number of buildings and operators in the province with just a handful of units – particularly those serving smaller communities – who could be encouraged to submit joint applications. Regardless of these variables, the maximum potential cost of $40,825,740 needs to be considered in initial projections.

BC Housing would also need to hire administrative staff to oversee the creation, operation, and evaluation of this program. An assessment of grant manager workloads conducted by the Washington State Recreation and Conservation Office suggests a maximum workload of 85 projects (Berk & Associates, 2008). However, it notes that this varies widely based on the complexity of the programs, the manager's skill and experience, and a host of other factors (Berk & Associates, 2008). Because these workers would be creating and administering a single, simple, and recurring funding stream, and because BC Housing already has staff in similar roles, it is likely that just a handful of new positions would be needed. While managers within BC Housing should be engaged with in a more fulsome development of this option and their feedback incorporated, for planning purposes it is estimated that five new full-time positions will be required. According to the BC Government (n.d.), salaries for provincial community program officers range from $49,531.50 to $61,096.97. Using the mid-point of this scale as a reference point, the annual cost of salary and benefits for this role would be $60.464.56. This would require a total of $302,323 to staff five positions.

Given these figures, the maximum cost of this policy option would be $41,128,063. While this is a considerable sum, BC Housing's 2018-19 expenditures

totaled $1.25 billion and this would amount to a budgetary increase of just 3.29% (BC Housing, 2019g). While the actual cost of this policy will likely be significantly lower than the maximum for the reasons discussed above, this will not be known until after implementation and the highest possible cost needs to be prepared for. As a result, this option receives the lowest possible score.

Administrative Complexity: Low

This option would require the hiring of multiple workers within BC Housing to oversee the development, implementation, and operation of the new granting stream. It would also result in the need for increased communication and collaboration both between BC Housing staff as well as between BC Housing staff and the nearly 600 non-profit partners who would be eligible to apply for these funds. As a result, it can be expected to result in significant administrative complexity and has received the lowest possible score.

Stakeholder Acceptance: High

This proposal received enthusiastic and overwhelming support from the vast majority of the thirteen experts and stakeholders interviewed for this report. Only one individual – a long-time resident of age-mixed seniors social housing – felt that it would not be effective based on their experience with staff in a similar role. Similar interventions have also been encouraged by the Vancouver Police Department in its reporting on the challenges posed by mental illnesses (Vancouver Police Department, 2013). With such a high degree of support from experts and stakeholders from across a number of relevant areas, it is reasonable to assume that this option would be widely received favourably. It has therefore been given the highest possible score.

8.2. Evaluation of policy option 2: Providing funding for after-hours security guards

Security and Protection:

Measure 1 (change in the number of seniors reporting victimization or the fear of victimization): **High**

Measure 2 (change in the number of police responses to age-mixed seniors' social housing facilities): **High**

There is evidence that security guards are effective in reducing crime in public places – including social housing facilities. The introduction of security staff to a high crime public housing estate in London produced compelling results. A comparison with a matching estate without similar staff found that the latter required 185% more vandalism-related repairs in common areas and 91% more vandalism-related repairs in elevators (Welsh et al., 2010). This resulted in a savings of $1.44 for every dollar spent (Welsh et al, 2010). Another study of 50 problematic public housing estates across the United Kingdom showed similarly positive outcomes. Here, 25 estates with security by design (SBD) interventions (including security guards) experienced a crime rate 17% lower than those without (Armitage 2000; Welsh et al., 2010). While initial evaluations found this to be just below the level of statistical significance, a follow-up study ten years later demonstrated statistically significant reductions in all measurable areas (Armitage and Monchuk, 2009). Of the 105 offenses documented in the follow-up report, 93 took place on non-SBD properties (Armitage and Monchuk, 2009). This criterion has accordingly been given the highest possible score in both measures.

Equity and Fairness:

Measure 1 (change in the amount of housing available to younger persons with severe mental illnesses and/or addictions): **High**

Measure 2 (change in the level of stigma experienced by younger persons with mental illnesses and/or addictions): **Low**

While security staff may be effective in reducing crime, they can also lead to problematic outcomes for vulnerable populations. This option will not reduce the amount of housing available to younger persons with mental illnesses and/or addictions, but it is likely to increase the level of stigma they face. A study of security guards working in Vancouver's Downtown Eastside, including some placed at supportive housing facilities and SROs, found that their presence led to greater social exclusion and more exposure to violence or aggression for drug-users and other at-risk groups (Marwick et al., 2015). It also increased the level of stigma these populations faced, something which has been shown to be positively correlated with the fears expressed by older adults

towards persons with mental illnesses and/or addictions (National Resource Center on Homelessness and Mental Illness, 1993; Marwick et al., 2015; Boyd and Kerr, 2016; Boyd et al., 2016). As a result, this criterion received a high score for the first measure and a low score for the second.

Budgetary Considerations: Medium

While slightly less expensive than funding resident service coordinators, providing after-hours security coverage for seniors' social housing facilities throughout the province would not be cheap. According to Payscale.com, security guards in British Columbia earn a median hourly wage of $15.05/hr., or $27,391 annually. With benefits, this increases to $29,875.68. Based on this figure, it would cost a maximum of $23,004,274 to provide at least one overnight security guard for each of the 770 seniors social housing facilities listed on the BC Housing Registry (BC Housing, 2019f).

Furthermore, as is the case with policy option 1, additional administrative staff would be needed at BC Housing to oversee the development and administration of the funding stream. As fewer security guards would be required when compared to the number of resident service coordinators needed, it seems reasonable to assume that one fewer staff person would be necessary. The estimated cost of filling four positions using the same figures presented in policy option 1 would be $241,858. However, this is again just a preliminary estimate and consultations with BC Housing managers would again be required to determine the most appropriate number of staff required to implement this intervention.

Additionally, in order to best position these guards for success and to minimize the negative impacts on younger tenants, training on how to deal with persons with mental illnesses would also be necessary (National Resource Center on Homelessness and Mental Illness, 1993). A quick search of mental health first aid training in the Lower Mainland region reveals a charge of $200 per training.[12] This would cost an additional $154,000 and leads to a final total of $23,400,132 for policy option 2. Because of this, a score of medium has been given to this criterion.

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[12] See https://www.mhfa.ca/

Administrative Complexity: Low

As described above, this approach would require the hiring of several new administrators at BC Housing and while also resulting in the need for more internal and external communication and collaboration between various staff, partners, and stakeholders. The lowest possible score has therefore been granted.

Stakeholder Acceptance: Low

Only three of the thirteen experts and stakeholders interviewed for this report indicated support for this option and all were lukewarm in their enthusiasm. The majority of those interviewed felt that the provision of medical and social supports was of much greater importance, that any increase in the stigma faced by younger residents with severe mental illnesses and/or addictions would be counter-productive to improving conditions within buildings, and that similar initiatives had proven ineffective in the past. This measure receives the lowest possible score as a result.

8.3. Evaluation of policy option 3: Institute segregated floors and access controls within buildings

Security and Protection:

> *Measure 1 (change in the number of seniors reporting victimization or the fear of victimization):* **Medium**

> *Measure 2 (change in the number of police responses to age-mixed seniors' social housing facilities):* **Medium**

There is evidence which suggests that access controls and other forms of Crime Prevention Through Environmental Design (CPTED) interventions are an effective means through which crime in public housing can be reduced. Indeed, instituting access controls in new public housing facilities is currently recommended by both BC Housing (2019i) and the City of Richmond (2015), amongst others. Evaluations from Seattle, Chicago, and Glasgow have found that CPTED approaches, including access control modifications, have led to "significant positive impact[s]" within public housing facilities

by reducing crimes such as drug use, burglary, attempted burglary, and theft (Feins, 1997; Lab, 2016).

However, this option only limits the opportunities for clashes and does not remove it entirely. Common areas such as lobbies, mail rooms, tenant lounges, and laundry rooms would still be uncontrolled and, as sources cited previously in the report have demonstrated, these areas are objects of considerable fear for older residents who live with younger persons with severe addictions and/or mental illnesses (ter Brugge, 2006). Additionally, access control has not been universally effective and has resulted in no appreciable reduction in crime in some jurisdictions (Feins, 1997). As a result, this criterion has been given a score of medium for both measures.

Equity and Fairness:

Measure 1 (change in the amount of housing available to younger persons with severe mental illnesses and/or addictions): **High**

Measure 2 (change in the level of stigma experienced by younger persons with mental illnesses and/or addictions): **Low**

As is the case with policy option 2, the reduction in crime that may result from instituting access controls is off-set by an increase in the inequitable treatment of younger tenants. Studies have found that housing-related access controls in particular have resulted in increased levels of discrimination faced by those considered "outsiders", though it should be noted that this research was not focused on public housing (Feins, 1997). This option is also likely to magnify seniors' perception of younger tenants as dangerous, leading to increased stigma.

Furthermore, while older adults would receive a degree of increased protection, other residents of seniors' social housing would not. Based on the studies reviewed for this capstone, just 6-34% of younger persons with mental illnesses and/or addictions living in publicly-funded seniors' housing have been identified as problematic (Heumann, 1996; Connecticut Legislative & Program Review Committee, 2004, Gaudette et al., 2018). Even if the highest figure is assumed to be accurate, 66% of younger residents pose no increased risk to their neighbours. While the variables which indicate the potential disposition towards violent or criminal behavior amongst the mentally ill

presented in Chapter 2 could potentially be used as the basis for further segregation, according to the experts interviewed for this report housing providers in BC are not permitted to make inquiries into the specifics of applicant's conditions. This option would therefore lead to younger persons with disabilities, many of whom experience the same physical vulnerabilities as seniors, being unfairly burdened with a disproportionate exposure to danger (Pynoos and Parrott, 1996). Based on these factors, this criterion has received a score of high for the first measure and a score of low for the second.

Budgetary Considerations: High

The industry average cost per controlled door in the United States ranges from $1,342 - $5,366 CAD (Rhodes, 2019). However, it is extremely difficult to come up with a credible projection of the costs associated with installing access controls in seniors' social housing without knowing the exact number of stairwells, floors, and elevators in each building across the province. Should this option be selected, housing providers across the province would be asked to provide this information. Regardless, this criterion has been given an estimated score of high based on the reasoning below.

While only an extremely rough estimate of the up-front costs of this option is possible, over the long-term it is likely to be considerably cheaper than the others. Once initial renovations are complete, operating costs should be comparatively minimal and there would be no annual salaries to be accounted for as would be the case with resident service coordinators and security guards. This option is therefore likely to be much cheaper than the others and has been scored accordingly.

Administrative Complexity: Low

This policy option is not possible without a significant expenditure of administrative resources. As noted in Chapter 2, persons living in social housing in BC are protected by the *Residential Tenancy Act*. This means that they can only be forced by landlords to leave their units under a small number of very specific conditions, none of which apply in this situation. In order for this to change, the *Residential Tenancy Act* would need to be amended. This would not be easily accomplished and would require considerable effort from public servants and politicians across a number of BC Government ministries. Furthermore, any attempt to do so would likely be met with legal challenges under both provincial and federal anti-discrimination laws, as was the case in

the United States when attempts were made to bar persons with mental illnesses from being eligible for housing in publicly-funded seniors' facilities (Cedrone, 2001).

Without making the changes described above which would allow residents to be compelled to move to different units within buildings, it would take years before any meaningful separation of the two groups could take place. With nearly 8,000 people currently waitlisted for seniors' social housing in BC and just over 500 people offered placement each year, it would be an extremely drawn-out process to achieve segregation through the natural process of attrition.

Finally, even if the *Residential Tenancy Act* was successfully amended and legal challenges forestalled, administrative staff would then be required to facilitate the movement of tenants within buildings and to oversee the funding which housing providers would need to cover the necessary renovations to implement access controls. As a result, this criterion has received a score of low.

Stakeholder Acceptance: Low

Just two of the thirteen experts and stakeholders interviewed for this report were in favour of any form of segregation, and one of these individuals was opposed to any solutions which continued to house seniors and younger persons with severely mental illnesses or addictions in the same buildings. A number of reasons were given by opponents, from the increased stigma that would result for mentally ill residents, to concerns about the establishment of a visibly inequitable system similar to that of "poor doors" within social housing facilities, to a desire to avoid any interventions which would lead to an increased atmosphere of institutionalization. This criterion has therefore received a low score.

8.4. Evaluation of policy option 4: Status quo plus additional research and pilot projects

Security and Protection:

Measure 1 (change in the number of seniors reporting victimization or the fear of victimization): **Low**

Measure 2 (change in the number of police responses to age-mixed seniors' social housing facilities): **Low**

While conducting further research and implementing pilot projects will lead to the identification of the most effective policy interventions and, assuming those are widely adopted, lead to a significant increase in the security and protection accorded to elderly residents of seniors' social housing, in the short and medium-term it does nothing to improve conditions for the vast majority of older tenants. As a result, a score of low has been given for both measures.

Equity and Fairness:

Measure 1 (change in the amount of housing available to younger persons with severe mental illnesses and/or addictions): **Medium**

Measure 2 (change in the level of stigma experienced by younger persons with mental illnesses and/or addictions): **Medium**

Neither significant reductions in the housing available to younger persons with disabilities nor increases in the level of stigma they face are likely to immediately result from this option. However, it is reasonable to assume that protection-oriented interventions would occur as pilot projects and could subsequently be chosen for wider implementation. This would undoubtedly result in negative impacts on younger residents. A score of medium has been accordingly assessed for both measures.

Budgetary Considerations: High

While the costs associated with research studies can be considerable, they pale in comparison to the potential expenses associated with the other policy options presented in this capstone. Even a two-year study involving an environmental scan, multiple pilot sites, and a credible evaluative process is unlikely to exceed $10 million. A sample budget for a two-year research project provided by the Ontario Ministry of Health and Long-term Care estimates staffing, equipment, and incidental costs totaling just under $350,000 (Ontario Ministry of Health and Long-term Care, n.d.). Even if there were ten different pilot projects, the total costs would be $3,500,000 – well below the $10 million threshold. This option therefore receives the highest score in this category.

Administrative Complexity: High

By outsourcing the research to a 3rd party, significant increases in administrative complexity will not be required. While BC Housing staff would need to create and monitor budgets and to help determine which facilities are most suitable for pilot projects, this should be relatively simple for existing research and community development staff to include as part of their regular activities. No new workers are likely to be needed and no significant expansion of the roles of existing staff should be necessary. Therefore, the highest possible score has been granted.

Stakeholder Acceptance: High

Eleven of the thirteen experts and stakeholders interviewed for this paper expressed their support for this option, with many doing so vigorously. While none felt that simply maintaining the status quo was acceptable, several voiced frustration regarding the lack of awareness of what is currently being done by individual housing providers and were certain that effective and scalable interventions were already occurring. They felt that an environmental scan alone would be incredibly valuable and would lead to a collection of best practices which would significantly improve the quality of life for residents of seniors' social housing. This measure received the highest possible score as a result.

8.5. Summary of policy option evaluations

Table 6:   Results of policy option analysis

	Policy option 1	Policy option 2	Policy option 3	Policy option 4
Security and protection (2x)	6	6	4	2
Equity and fairness (2x)	6	4	4	4
Budgetary considerations	1	2	3	3
Administrative complexity	1	1	1	3
Stakeholder acceptance	3	1	1	3
Total	**17**	**14**	**13**	**15**

As summarized above in Table 6, *policy option 1: providing funding for resident service coordinator positions* scores highly in the two most important categories: security and protection of seniors, and equity and fairness for younger tenants. It was also the

option most strongly supported by the experts and stakeholders who were interviewed for this report. However, this is somewhat balanced by it being both the most expensive option and one which is likely to require a significant increase in administrative complexity. *Policy option 2: providing funding for after-hours security guards* also scores highly in the security and protection for seniors, but has negative consequences for the younger group. It also does not do well in the other categories and has been rejected as a result. The same is largely true of *policy option 3: instituting segregated floors with access controls*, which offers less protection for older adults while being comparatively cheaper in the long-run. Because of this option low scores in the two most important categories, it too has been rejected. While *policy option 4: status quo plus additional research and pilot projects* does little to immediately improve conditions for seniors and has the potential to result in protection-oriented measures which negatively impact younger residents of seniors' social housing, it is relatively cheap, easy to administer, and strongly supported by the experts and stakeholders who were interviewed – several of whom that it had the opportunity to be most effective in the long-term.

Chapter 9.

Recommendations

9.1. Recommendation: Provide funding for resident service coordinators and conduct an environmental scan and evaluation of the initiatives currently in place

As displayed above in Table 5, policy options 1 and 4 receive scores significantly higher than options 2 and 3. Furthermore, there are no individual categories in which options 2 and 3 are preferable. They have therefore been rejected entirely.

It is the recommendation of this capstone that two concurrent policy interventions be implemented. First, funding for resident service coordinator positions should be made available to all providers of independent and supportive seniors' housing across the province. The literature and case studies reviewed for this paper suggests similar approaches have been unequivocally effective, staff in similar roles are demonstrably lacking in the majority of seniors' social housing facilities across the province, and this option has received widespread support from the experts and stakeholders interviewed for this paper. In order to best position these workers for success, a secondary recommendation is that BC Housing develop recommended competencies and educational materials to provide to funded organizations – a suggestion once interviewee working in non-profit housing administration described as "amazing". Fortunately, such resources in this area already exist. State housing authorities across the United States have produced detailed and widely applicable handbooks, and the Department of Housing and Urban Development has established a set of required competencies for resident support staff. These competencies are presented below in Table 7. It should not be an arduous task to tailor these for BC.

Table 7:   Required Areas of Competency for Resident Service Coordinators from the HUD[13]

• The aging process • Elder services • Disability services • Mental health issues • Legal liability issues relating to providing services	• Government entitlements • Medication/substance abuse • Strategies for communicating in difficult situations • Strategies for dealing with cognitive impairments

The second recommendation of this capstone is that an environmental scan and evaluation of existing interventions take place concurrent to the above. Numerous interviewees asserted that there are likely a range of approaches to this issue which have already proven successful in BC – they are just not widely known because of the diffuse and siloed nature of social housing in the province. Collecting this data will lead to two positive outcomes. First, it will identify what is working and assess its potential for scalability. Second, it will help meet the need for contemporary, BC-specific data on a subject matter which has to this point been considerably under-researched. Both will prove extremely valuable to the current and future needs of those living in seniors' social housing in the province.

[13] This list is taken from the 2019 edition of the Resident Service Coordinator Resource Guidebook created by the Connecticut Interagency Council on Supportive Housing and Homelessness.

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Appendix.

An interviewee described their experience in age-mixed seniors' social housing

My Lived Experience

My experience of living in subsidized social housing, with a mix of people age 19 and older including senior population aged 55 to 90 plus, was very stressful. It impacted my ability to have restful sleep at night. I had neighbours who had TVs and radios on all night long. There were drug dealers, sex trade workers, and homeless people having easy access into my building because they were buzzed in as "guests" . Cars would pull up at 3:00 am and stay for only 3 to 5 min... drug deals being transacted. Young 20 year olds having friends and partying on their balcony till all hours late into the night. People running up and down the hall way after 12:00 at night.

I did not feel safe within my building. There were individuals with mental illness and some had substance use issues as well. Often interactions with them was challenging because their behaviours in response to what you said could lead to them acting in unanticipated ways. One such tenant always needed, when getting on the elevator, to walk to the very back corner and not say a word. Another man who told me he was schizophrenic was also drinking alcohol nearly everyday. I would wake up in the morning to the sounds of him violently throwing up. This same individual also started a paper fire in his kitchen sink because the staff in his program had refused him the use of their paper shredder. The smoke from his fire set off the fire alarms for the building, my apartment filled with smoke, and when I went down to find out what was happening, he was so drunk he was slurring his words and refused to put out his fire. The fire department had to come and he was sent to the hospital for assessment. But, he was not evicted for his dangerous behaviour.

There were incidents of elderly people being taken advantage of by the street people who gained access to the building. Some had money stolen out of their purses, others had their bank cards taken, and I know of at least two tenants who were in the program for mental health have their apartments taken over and lived in by drug using

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street people. In fact, one building ended up with a police SWAT squad doing a raid on an apartment because of suspected drug dealing. They found drugs, guns and money. Many seniors in that building began to search for safer housing no matter the cost. They moved out as soon as they could.

Over time my building housed several kinds of people under at least three different agencies. The people in these programs had workers and had representation on their behalf with the landlord. The one group that seemed to be overlooked were the seniors population. When events occurred that were a threat to their safety there was no organization representing their concerns. The interactions between the tenants became increasingly more difficult to navigate as the complexity of the mix of populations, each with their own set of diverse needs, started to create an environment of continual disturbance.

I started to take on dog sitting for friends just to get away from all the craziness in my building. It afforded me a week or weekend away where I was in a quiet neighbourhood. I had some moments of normality in my life and I could relax and actually get a good nights sleep.

I tried to gain a voice for the seniors and worked hard to try to make a difference. I wrote up a proposal asking for a study to be done to monitor how the complex mix of age and needs of people of varying groups all in high density social housing was actually affecting all concerned. Unfortunately it was an unwanted voice. The landlord did not want to hear about the problems, the head of the local government office saw no need to look into impacts their program was having, the hospital did not want to have scrutiny into their patients referral, and the Health Authority claimed that there had been no complaints to them about what was going on in my housing. It was very upsetting to have to push against the lack of interest in setting up a way to monitor the housing of complex mixed group all together in one housing provider. Lesson learned and best practices for policy and planning seemed to be more a threat or too much of a financial expense to seriously be implemented. I even took part in seeking outside help with a local seniors centre. I was part of a group that presented concerns to the Seniors Advocate of the Province. Sadly, the Seniors Advocate suggested the solution to consider was to take matters to the Landlord Tenancy process.

It was so discouraging to see the lack of will to hear that people, all the people, in social housing are suffering distress, poor emotional health, and having their physical health suffer as a result of the stress load. BC Housing answered my question about whether there was any research done that would support housing all groups together in social housing with the answer that there was no robust research concerning this. Yet, they are willing to spend tax payers money to fund housing projects that are designed at the onset to house mixed ages, mixed needs, and mixed health issues. All within high density housing. I felt so UNHEARD.

So, that is what was and what I experienced. I had an emotional and physical burn out. I ended up in hospital for help with stress, depression, hopelessness and feeling suicidal. I decided I could not go back to the chaos of my housing. I had no where to go, but I could not live there any longer. I ended up moving in with family. I took some respite time to calm my nerves. Then, went to an agency to help me find housing that would be affordable and suitable for my personal needs. Feeling safe in my own apartment and building was key. I found out that housing is not available in my price range except to be put on wait lists. Many of the lists require a 5 year wait time. Even more depressing is the reality that any subsidized BC Housing or non-profit housing will have mixed age/needs populations very similar or even worse to what I had been living in.

What is my situation now? The building is for seniors age 60 plus only. The building manager is very careful to screen possible new tenants for compatibility with current tenants. So I am in a more homogeneous age mix in my building. Most importantly I feel safe. There is every effort to encourage healthy and happy interactions among tenants. The building is quiet past 10:00 at night. I am finally able to have a peaceful environment where I actually can get a good nights sleep. My health has improved and my stress level is significantly reduced. I am finally in housing that is compatible with my needs.