

# **A Survey of Domiciliary Hostel Program Tenants in Ontario**

## **Highlights Report**

Dr. Stephen Hwang, Shirley Chiu, and Emma Wilkins  
From the Centre for Research on Inner City Health,  
The Keenan Research Centre in the  
Li Ka Shing Knowledge Institute of  
St. Michael's Hospital  
30 Bond St.  
Toronto, Ontario M5B 1W8

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## INTRODUCTION

### *History on Domiciliary Hostels\**

In the late 1950s, municipalities began to provide financial support for impoverished adults living in unregulated lodging or boarding homes. In the early 1970s, the province of Ontario began to develop more formalized policies to help provide adults who would be otherwise homeless with shelter and basic needs in lieu of direct financial assistance. After proclamation of the *Nursing Homes Act (1972)*, municipalities began to access provincial funding to provide longer-term accommodation to those persons who did not meet the requirements of the new Act (e.g. to those who required assistance with activities of daily living but who did not require regular nursing care). The name 'Domiciliary Hostel' emerged as a term used to describe a range of housing operations that received funding to provide board and lodging and some support for activities of daily living on a per-bed basis. Domiciliary Hostels were initially created as a municipal response to meet the housing needs of impoverished frail/elderly adults. Over the years the program has evolved to become permanent housing for vulnerable adults with a wide range of special service needs, such as persons with mental illness, physical and/or developmental disabilities and/or frail elderly.

Prior to 1998, the province cost-shared the Domiciliary Hostel Program with municipalities (80% provincial/20% municipal). As of January 1998, under the Local Services Realignment process, the Domiciliary Hostel Program was identified as being entirely a municipal responsibility. This decision was reversed following the recommendations of the Provincial Task Force on Homelessness. In June 1998, the province made a commitment to review the Domiciliary Hostel Program and agreed to again cost-share the program with municipalities (80% provincial/20% municipal).

The province currently has very limited reliable information about tenants in Domiciliary Hostels, the circumstances that bring people to the hostels, and the circumstances in which they live. One provincial-level investigation, carried out in 1999, sought to develop a profile of the Domiciliary Hostel Program (Sigma – 3 Policy Research Inc., 1999). Research methods included a survey of operators, site visits and a literature review. Although this study suggests that Domiciliary Hostel tenants have service needs related to mental illness, physical disability, developmental disability and substance abuse, the findings are limited by the study's reliance on second-hand information concerning tenant characteristics and needs. To support policy work and service planning, both the Ontario Ministry of Community and Social Services (MCSS) and the Ontario Ministry of Health and Long-term Care (MOHLTC) require descriptive information about Domiciliary Hostel tenants and their service needs.

\*Note: The History on Domiciliary Hostels section was prepared by MCSS.

## **STUDY OBJECTIVES**

The goal of this project is to support policy work and service planning by providing reliable information about the characteristics and service needs of tenants in the Domiciliary Hostel Program in Ontario. The specific objectives of this research project were:

- 1) To describe the characteristics of Domiciliary Hostel Program tenants;
- 2) To describe Domiciliary Hostel Program tenants' use of community supports and services, use of health care, and participation in community life; and
- 3) To describe the housing pathways of Domiciliary Hostel Program tenants.

Data were collected through face-to-face interviews with a representative sample of Domiciliary Hostel Program tenants in 8 CMSMs. Additional information on study participants was obtained through linkages with provincial databases.

## **METHODS**

### *Research Team and Project Advisory Committee*

This study was commissioned through a Request for Proposals issued by the Ontario Mental Health Foundation (OMHF), Ontario MOHLC, and Ontario MCSS. The study was conducted by Dr. Stephen Hwang, a research scientist at the Centre for Research on Inner City Health (CRICH), St. Michael's Hospital, Toronto, and his research team at CRICH.

The Project Advisory Committee (PAC) consisted of representatives from the Ontario MCSS, MOHLTC, Consolidated Municipal Service Managers (CMSMs) and District Social Service Administration Boards (DSSABs), Ontario Homes for Special Needs Association (OHSNA), Habitat Services, and the tenants' association. Throughout the course of the project, the PAC convened periodically to discuss and provide feedback to the research team concerning the survey instrument, methods and process, deliverables, and knowledge transfer.

### *Sampling Methods*

There are 25 CMSMs in the province of Ontario that house approximately 4,700 Domiciliary Hostel funded tenants. Individuals were surveyed in 8 CMSMs (Windsor, Essex County, Waterloo, Hamilton, York Region, Ottawa-Carleton, Prescott-Russell, and Cornwall), which account for about 4,000 program beds (about 85% of all beds in the province). The remaining 17 CMSMs account for only about 700 Domiciliary Hostel program beds (about 15% of all beds in the province). For this descriptive study, a sample size of 250 participants was selected to provide estimates that were generally accurate to within plus or minus 6%.

The number of individuals recruited in each CMSM was proportionate to the number of Domiciliary Hostel beds in that CMSM. For example, the Windsor CMSM had 355

Domiciliary Hostel beds, which represented 9% of the total of 4,024 beds across the 8 CMSMs in the study. Thus, approximately 9% of study participants were recruited in the Windsor CMSM. Domiciliary Hostels were randomly selected within each CMSM and potential participants were randomly selected from within each of the selected Domiciliary Hostels.

Prior to commencing the research, MCSS provided information about the study to all municipalities and Domiciliary Hostel Operators in the province. Once Domiciliary Hostels were randomly selected by the research team, each CMSM then sent letters of notification to the Domiciliary Hostels that had been selected for participation in the study. The research team then telephoned the operators of these sites to obtain permission to recruit participants at their facility. At least 4 attempts were made to contact each operator. In the event of a refusal, an alternate site within the same CMSM was selected.

Most sites had a mix of privately-funded and Domiciliary Hostel program-funded tenants, but only Domiciliary Hostel program-funded tenants were eligible for selection. The research team and Domiciliary Hostel staff then worked together to locate the eligible and willing study participants. Bilingual research team members approached and interviewed individuals whose preferred language was French. Tenants were deemed ineligible if they had severely impaired mental capacity or were unable to participate in the informed consent process, as determined by the research team or the Domiciliary Hostel staff/operator. If the selected resident was not present at the time of recruitment (e.g., due to a doctor's appointment or participation in a day program), another resident was randomly selected. Throughout the selection process, measures were taken to ensure the confidentiality of all tenants at each site.

### *Survey Instrument*

The survey instrument was designed to be administered using pen-and-paper and constructed in English by the research team in consultation with the PAC. Items were drawn based upon the research team's large experience of conducting similar surveys with homeless and vulnerably housed individuals. Whenever possible, items were obtained from previously validated instruments. The survey instrument was pilot tested with 12 participants at Habitat Services in Toronto<sup>1</sup> and revised to improve flow and ease of administration, and reduce burden on the participants. Approval for the minor modifications was provided by PAC and OMHF.

The survey instrument and consent form were translated to French by a professional translation service. The back-translation was carried out independent of the translation service by two CRICH bilingual Research Assistants.

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<sup>1</sup> There are no Domiciliary Hostels in Toronto. Pilot tests were conducted at two Habitat Services sites in Toronto as it provided the research team with the opportunity to interview a group comparable to Domiciliary Hostel residents. Habitat Services provides housing to tenants with serious mental health issues in private sector board and care settings.

## *Ethics and Data analysis*

All study participants gave written informed consent to participate in the study and received \$20 for completing the survey. This study was reviewed and approved by the St. Michael's Hospital Research Ethics Board. Interview and provincial data was entered and analyzed using SPSS 16.0, an analytic software.

## **RESULTS**

### *Demographic Characteristics*

Between January and May of 2008, a total of 258 participants from 54 Domiciliary Hostels enrolled in the study (response rate of 71%). Study participants had the following characteristics:

- 59% were male,
- 77% were under the age of 65 years,
- 90% were white,
- 50% were single/never married,
- 54% did not graduate from high school,
- 96% were not currently working in any paid position,
- 90% spoke English as their primary language,
- 98% were Canadian citizens, and
- 88% were residents of Ontario for 20 years or more.

Tenants under 65 years tended to be male (65%), meanwhile, tenants 65 years and older tended to be female (63%).

### *Physical Health Conditions and Developmental Disability*

The majority of participants (89%) reported having at least one physical health condition. The most commonly reported physical health conditions were arthritis/rheumatism/joint problems, difficulty walking, high blood pressure, diabetes, asthma, chronic bronchitis/emphysema, epilepsy/seizures, anemia, heart attack, and skin disease, and stroke. A developmental disability was reported by 21% of the participants, and 30% reported having developmental, learning or other disabilities.

### *Diagnosed Mental Health Issues and Substance Use*

Domiciliary Hostel tenants had a very high prevalence of mental health issues: 73% of the participants reported being diagnosed with at least one mental health issue (excluding substance abuse/dependence) and 52% reported being diagnosed with at least one of the following serious mental health issues: schizophrenia, psychosis other than schizophrenia, bipolar affective disorder (manic-depressive illness), and manic disorder. The majority of study participants (64%) reported no use of any alcohol or drugs in the last 3 years. Based on the Global Appraisal of Individual Needs (GAIN) instrument, 8% of participants were classified as having a moderate level of substance dependence in the last 1 year, and 5% were classified as having a high level of substance dependence. A total of 23% of the participants had used

alcohol and/or drugs in the last 3 years but were classified as having no/low level of substance dependence.

### *Quality of Life*

Compared to the Canadian population, Domiciliary Hostel tenants were substantially more likely to report experiencing problems with mobility, usual activities, self-care, pain/discomfort, and anxiety/depression. Their self-rated health-related quality of life was also poorer (11 points lower) than that of the Canadian population.

### *Health Care*

Most participants (87%) reported that they had a health care provider, which was in most cases a family doctor. It was more common for the participant to go see his or her family doctor at the doctor's office (64%) than for the family doctor to come to see the participant at the Domiciliary Hostel (38%). A total of 40% of participants had a psychiatrist whom they saw regularly. Overall satisfaction with the way health care services had been provided during the last 12 months was high, with 81% of participants reporting that they were very satisfied or somewhat satisfied. A total of 41% of participants reported that they were accompanied during health care visits. Among these participants, the person accompanying them was most commonly the Domiciliary Hostel staff or operator (37%) or a family member or friend (35%). The vast majority (97%) of participants were taking prescribed medications, of which 79% of these participants reported receiving help taking their medications. The person assisting them with their medications was most often the Domiciliary Hostel staff or operator (64%) or a nurse working at the Domiciliary Hostel (32%).

### *Support Services and Community Life*

A total of 43% of participants reported that they had a support worker<sup>2</sup> who helped them access services, and the same percentage reported using some type of community services/supports in the past 12 months or during the period they had resided in the Domiciliary Hostel (if less than 12 months). The most commonly used services/supports included mental health programs, drop-in services, religious services, addiction services, and activities offered on-site or off-site, such as arts and crafts, movies, bingo, social outings, and recreational activities like bowling, exercising, and dancing. Of all the types of community services/supports used by the participants, one-third of the services/supports were provided at the Domiciliary Hostel. The most common services/supports provided at the Domiciliary Hostel were activities (e.g., visiting a shopping centre or community centre), religious services, Assertive Community Treatment, mental health programs, and city social services. Participants' level of involvement in community activities in the last 12 months or for the duration they had resided in the Domiciliary Hostel (if less than 12 months) was generally low. The only activities that more than half of participants reported engaging in sometimes, often, or very often were going for a walk (77%), going to a

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<sup>2</sup> The term 'support worker' was not defined for tenants and therefore tenants may have included individuals such as Domiciliary Hostel staff who provided assistance in accessing services.

restaurant, bar, or coffee shop (62%), and going to a shopping centre or large shopping area (59%). Barriers to involvement or participation in community activities were not assessed as part of this study.

### *Social Supports and Personal Choice*

Perceived support was relatively high, with 80% of participants reporting that there was at least one person with whom they felt at ease and could talk to about personal issues. Among these participants, the most common persons identified included friends (75%), family (72%) and Domiciliary Hostel staff or operator (68%). The majority of participants felt that they were provided with choices while living at the Domiciliary Hostel. More than 75% of the participants felt they had choice related to finances (how to spend their money) and bedtimes, and felt able to register complaints about the hostel with hostel staff and to disagree with the hostel staff.

### *Housing*

Participants tended to be long-term Domiciliary Hostel tenants, with the average duration of tenancy at the current Domiciliary Hostel being 5.1 years. Tenants were most likely to have moved into their current residence from their own house or family's house (28%), an apartment (28%), or another Domiciliary Hostel (17%). The three most common types of residences that both non-seniors and seniors had lived in prior to moving to their current Domiciliary Hostel included their own/family house, apartment, and another Domiciliary Hostel. The most common reasons that tenants cited for moving into their current Domiciliary Hostel were mental health issues, a change in family situation, the desire to move to a better residence, their physical health conditions, the need for assistance with daily living/administration of medications, and their previous residence was no longer available. A total of 35% of participants had been homeless in their lifetime. However, this experience was usually not recent, with the last episode of homelessness occurring an average of about 10 years ago.

Participants reported a relatively high level of perceived housing quality at their current Domiciliary Hostel. The average quality score was 33.8, where six represents the worst possible score and 42 represents the best possible score. A total of 87% of tenants reported that they liked at least some aspects about living at the hostel, and 48% disliked at least some aspects about the hostel. When asked about their preferences, 63% of participants stated they would prefer to stay at their current Domiciliary Hostel, whereas 33% would prefer to move elsewhere. Among the tenants who indicated they preferred to move elsewhere or were unsure, 56% stated that they planned to move within the next 6 months. The three most common types of housing desired by these tenants were an apartment, own/family house, and another Domiciliary Hostel.

### *Comparison of Physical and Mental Health Issues, and Developmental and Learning Disabilities by Age*

Individuals younger than age 65 years (non-seniors) were significantly different from those who were age 65 years and over (seniors). Non-seniors were more likely to have developmental, learning or other disabilities, head injury, mental health issues (excluding substance abuse/dependence), serious mental health issues, self-reported substance abuse/dependence, and to have used alcohol or drugs in the last 3 years.

### *Health, Use of Community Services/Supports, and Involvement in Community Activities of Participants: Subgroup Comparisons*

The interviews indicated that Domiciliary Hostels serve individuals with diverse characteristics and service needs. Additional analyses were conducted to examine differences by age group (non-seniors versus seniors), facility size (smaller versus larger facilities), duration of tenancy in the current domiciliary hostel (short-term versus long-term tenants), serious mental health issues (presence versus absence), developmental disability (presence versus absence), and developmental, learning or other disabilities. Findings from the subgroup comparisons are included in **Table 1**. For each of the subgroup analyses, the table presents the subgroups that had more positive outcomes in the areas assessed. For example, non-seniors had better physical health status than seniors, and tenants with developmental disabilities had better community integration than tenants without developmental disabilities.

### *Data Linkage with the Provincial Database*

A substantial proportion of Domiciliary Hostel tenants received financial assistance from the Ontario Disability Support Program (ODSP) or Ontario Works (OW). An ODSP/OW identifier was obtained for 191 (74%) of participants. Linkage with the Ministry of Community and Social Services and Ministry of Health and Long-Term Care databases was successful for 178 individuals (69% of all participants and 93% of those for whom a number was obtained). Among these participants, most were receiving ODSP benefits (94%), a very small proportion were receiving OW benefits (3%), and 3% had received ODSP/OW benefits but were no longer receiving them. The mean number of moves between January 1, 2003 and May 31, 2008 was 2.6. Meanwhile, 30% had 0 moves, 35% had 1-4 moves, and 20% had 5 or more moves between this period.

For the 178 participants whose social assistance data could be accessed, the most common primary and secondary ICD-9 diagnoses were schizophrenia (41%), developmental delay/mental retardation (15%), personality disorders (12%), neurotic disorders (12%), affective psychoses (8%), and epilepsy (4%). The self-reported presence of certain conditions was compared to ODSP disability determination files to determine the concordance between these two data sources. In the 178 participants for whom data linkage was accomplished, the disability determination file confirmed the diagnosis of schizophrenia or psychosis in 67% of the individuals who self-reported these diagnoses. In comparison, the corresponding figures were only 22%

for individuals who self-reported a diagnosis of developmental disabilities, 20% for individuals who self-reported a diagnosis of bipolar/manic, and 25% for individuals who self-reported any other mental health diagnosis.

These relatively low figures for the correlation of self-reported developmental disabilities, bipolar/manic, and other mental health diagnoses with ODSP disability diagnoses may be due to a number of factors. First, an individual may accurately self-report that they have a specific condition (e.g., developmental disability), but they may have qualified for disability on the basis of a different condition (e.g., epilepsy). Second, the disability determination file contains only the individual's primary and secondary diagnoses; thus, for an individual with three or more conditions, the disability file will fail to confirm at least some of these diagnoses. Third, individuals may report a condition that is in a different category than the diagnosis assigned by the disability determination process (e.g., an individual may self-report bipolar disorder but have been assigned the ICD-9 code for major depression). Fourth, the individual may have "no disability" listed as their primary ICD-9 code, for the reasons given above. Finally, individuals may self-report conditions (e.g. depression) that have not been formally confirmed by a health care provider. Overall, these findings emphasize the fact that a formal diagnostic interview or a careful review of medical records, not correlation to the disability determination file, would be a preferable method of confirming self-reported diagnoses of developmental disabilities or mental health diagnoses.

## **DISCUSSION**

### *Strengths and Limitations of the Study*

This study has a number of major strengths. It provides reliable and detailed information about Domiciliary Hostel tenants that was obtained through face-to-face interviews with a representative sample of tenants and through linkages with disability databases. The level of cooperation from Domiciliary Hostel operators was very high, and 71% of eligible tenants agreed to participate in the study. Rigorous research methods were used to ensure the highest possible standards of data quality and analysis.

Certain limitations of this study should be kept in mind. In particular, this study did not sample tenants in 17 CMSMs that account for 15% of Domiciliary Hostel beds in Ontario, and the results of this study may not be generalizable to these jurisdictions. In addition, 13% of individuals approached for possible participation in this study were deemed ineligible, primarily due to an inability to converse appropriately. These individuals may therefore represent a subgroup of Domiciliary Hostel tenants who have higher levels of disability and illness than those who were recruited in the study. As a result, our findings may underestimate the levels of illness or disability among Domiciliary Hostel tenants overall.

**Table 1: Subgroup Comparisons**

	<b>Better Physical Health Status<sup>3</sup></b>	<b>Better Mental Health Status<sup>4</sup></b>	<b>Better Community Integration<sup>5</sup></b>	<b>More use of Community Services and Supports<sup>6</sup></b>	<b>More Likely to have a Support Worker to assist with Accessing Services</b>	<b>Younger<sup>7</sup></b>
Seniors vs. Non-seniors	Non-seniors	Seniors	Non-seniors	Non-seniors	Non-seniors	
Smaller vs. Larger facilities	ND	ND	Tenants in smaller facilities	Tenants in smaller facilities	Tenants in larger facilities	Tenants in smaller facilities
Long-term vs. Short-term tenants	ND	Long-term tenants	Long-term tenants	Short-term tenants	Long-term tenants	Short-term tenants
Tenants with vs. without serious mental health issues	ND	Tenants without serious mental health issues	Tenants with serious mental health issues	Tenants with serious mental health issues	Tenants with serious mental health issues	Tenants without serious mental health issues
Tenants with vs. without developmental disabilities	ND	Tenants without developmental disabilities	Tenants with developmental disabilities	Tenants with developmental disabilities	Tenants with developmental disabilities	Tenants with developmental disabilities
Tenants with vs. without developmental, learning or other disabilities	ND	Tenants without developmental, learning or other disabilities	Tenants with developmental, learning or other disabilities	Tenants with developmental, learning or other disabilities	Tenants with developmental, learning or other disabilities	Tenants with developmental, learning or other disabilities

Note: ND = No Difference

<sup>3</sup> Measured using the SF-12 Health Survey Mean Physical component subscale score.

<sup>4</sup> Measured using the SF-12 Health Survey Mean Mental component subscale score.

<sup>5</sup> In the last 12 months or during the duration they had resided in the current Domiciliary Hostel (if less than 12 months). Community integration as measured using the mean Community Activities Score tended to be low among all groups, although certain subgroups displayed better community integration when compared to their counterparts.

<sup>6</sup> In the last 12 months or during the duration they had resided in the current Domiciliary Hostel (if less than 12 months).

<sup>7</sup> Measured using mean age of tenants.

### *Implications and Conclusions*

In summary, this study provides reliable and valuable information about the characteristics of Domiciliary Hostel tenants in Ontario. Since the inception of the Domiciliary Hostel Program more than three decades ago, this program has clearly evolved from housing frail seniors to housing a diverse group of vulnerable adults, including individuals with mental health issues and physical illness, developmental disabilities, as well as the elderly. Domiciliary Hostel staff assist tenants in a number of ways, including taking their prescribed medications, accompanying them for health visits, and providing social support. Nonetheless, these individuals tend to use relatively few community services and to have low levels of involvement in community activities. Tenants of Domiciliary Hostels generally perceive the quality of their housing to be quite good, and 63% express a preference to stay at their current residence. While it is beyond the scope of this report to make specific policy or program recommendations, it is hoped that the information in this report will be useful in supporting future policy and program planning.