SETTLING IN OR JUST SETTLING? EXPLORING OLDER ADULTS' NARRATIVES OF RELOCATION TO ASSISTED LIVING

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Abstract

Since 2001, British Columbia has seen an expansion in the assisted living (AL) segment of supportive housing for older adults. Values associated with AL typically include independence, choice, self-direction, and autonomy, which position it as an attractive alternative to traditional residential care models or 'nursing homes.' Yet, there have been few studies that critically examine AL in the Canadian context. Such investigations are important because of the variation in AL facilities internationally. Also, there is lack of research generally on the significance of the transition to AL for older adults or what their experiences are once they have arrived.

The purpose of this study was therefore to explore older adults' narratives of moving to AL, in order to learn about their relocation experiences and how they fit with the overarching goals and values of AL. To do this, the study employed thematic content analysis of 18 provincially-focused, publicly available documents about AL. Collectively, the documents addressed both service users and providers and spoke to expectations and regulations for service delivery. The study also employed multi-level narrative analysis of four older adults' relocation stories, gathered over the period of a year.

Findings from the study indicate that there are tensions between the foundational values and purposes of AL, how these are operationalized at the facility level, and how they are experienced by those moving in. While participants were generally pleased with the supportive and health care services they accessed by relocating, their accounts also highlighted a lack of social connection within AL and restrictions to choice in a variety of areas including dining and recreational pursuits. However, the findings also illuminate positive and innovative practices that

can ease the transition to AL. Recommendations include: 1) finding avenues for residents to express their choices in meaningful ways, such as increasing resident input at an organizational level and expanding the type of activities offered; and 2) offering more deliberate facilitation of social and place connections in AL through an increased role for social workers in AL, peer support programs, and stronger community ties.

Lay Summary

Since 2001, assisted living (AL) has become a popular type of housing plus supportive care for older adults in British Columbia. Values associated with AL typically include independence, choice, self-direction, and autonomy, which position it as an attractive alternative to traditional residential care models or 'nursing homes.' This study examined the relocation stories of older adults who had moved to AL, as well as documents related to advertising and regulating AL in this province. The findings show that there are some tensions between the guiding values of AL and how services are carried out in facilities. While participants were generally satisfied with the personal care services they received, they were less content with meals and the social and recreational opportunities offered. Participants' insights were used to generate recommendations that could improve the relocation and settling in process older adults.

Preface

This dissertation is an original intellectual product designed, conducted and written by the author, Jasmyne Rockwell. Ethical approval for this research study was obtained from the University of British Columbia's Behavioural Research Ethics Board. The certificate number for the study entitled 'Settling in: Exploring older adults' narratives of relocation to assisted living,' is H13-00043.

Links to internet pages and documents referenced in this dissertation have been checked for functionality as of September 18, 2017.

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List of Abbreviations

AL – Assisted living

ADL – Activities of daily living

IADL – Instrumental activities of daily living

QOL – Quality of life

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To Beatrix and Jasper, two very important chapters in my life.

To my mom, who never doubted that I could (or should).

To my dad, who would have read every word.

Chapter 1: Introduction

1.1 Point of entry

I worked, for a time, as a social worker on an acute care ward for older adults. In this setting, patients and their families often had to grapple with the difficult reality that the older adult could no longer remain in their home, even with support. For individuals with the most complex medical needs who were to transition to long term residential care[1], the hospital staff and dedicated transition team were available to assess, counsel, and place the individual. For those moving to assisted living, however, I often felt at a loss as to what to say or do. Assisted living (AL) was the purview of community case workers, and as I had only just started working in health care I did not know much about the system 'out there,' off the ward. My involvement in these cases was mostly related to recovery and the practicalities of returning home. In terms of AL resources, all I had to offer was a sympathetic ear and a small publication of property listings across the province. The message I took in was that moving to AL was somehow better, or at least less drastic a change, than moving to a long term residential care facility. Yet, I could see that the weight of the pending relocation was felt just as deeply by older adults and families.

Eventually I moved to a position as a social worker in a long term residential care facility, where I worked on the other side of the relocation process to receive and settle new residents. There were ample issues and questions to study in this environment, some of which I researched during my Masters degree. Yet, when I began my doctoral studies I found myself returning to the topic of older adults and AL. I had witnessed what it was like for individuals to

[1] For a definition of long term residential care, see sections 1.2.

enter into the highly organized environment of long term care, but I wondered what the experience would be like in a supposedly more independent environment. How did older adults feel about moving to AL? What was it like to live there? How did their expectations about AL match the reality of relocating? I began with a literature search, which identified several trends and gaps in the existing research that helped to define my research focus and questions. In particular, it became clear that 'assisted living' is a term that has been applied to similar, yet varying, models that are meant to espouse a core philosophy. In the following sections I present a brief history of the AL model of care and define the way that it is structured in British Columbia.

1.2 What is assisted living?

'Assisted living' refers to a level of housing plus some supportive and health care for older adults. The concept originated relatively recently in the United States, but has also been taken up other Western countries such as Canada, Australia, New Zealand, the Netherlands, and Sweden and the UK. However, understanding where it fits in the spectrum of care is challenging, because of the variations in terminology used internationally. Before discussing the evolution of AL in the United Sates and its spread to Canada, I will therefore briefly outline the different terms used in the two countries that are used to refer to similar types and levels of care.

In Canada, both 'continuing care' and 'long term care' are used to describe the entire spectrum of care for older adults, but 'long term care' and 'long term residential care' are also used in the majority of provinces and territories (including British Columbia) to refer to a facility that provides the maximum level of institutional care, employing 24-hour skilled nursing for the most physically/cognitively frail older adults. Of note for this study, some maximum-level facilities in British Columbia refer to their services as 'complex care', and I adopt this language

at points when this is the terminology used by the specific facility I am referring to. 'Residential care,' in Canada, generally refers to any kind of custodial facility for older adults with supportive or care services, including AL and long term residential care homes.

In contrast, 'long term care' is used in the United States as an overall term to describe a range of elder care services from in-home support to institutional care. Facilities providing maximum support are referred to as nursing homes. Therefore, although 'nursing home' is not as widely used in Canada, I use it at points where I am citing American literature. In the United States, 'residential care' and 'residential care homes' refer to various types of housing including assisted living, rest homes, and adult foster care, with the *exclusion* of nursing homes.

Keren Brown Wilson, one of the original AL advocates and operators in Oregon, has traced the development of AL from discrete beginnings on the East coast and West coast of the United States in the 1980s (Wilson, 2007). She asserts that "the early models of assisted living emerged in reaction to nursing facilities and a vision of a different way of bringing physical environments, care and service capacity, and philosophy together to offer a more desirable product to older people" (p.9). Key constructs in this early picture of AL remain ideological cornerstones of the model today. These include: 1) homelike environments that are adaptable to changing needs but also private and personalized; 2) the provision of services to enhance individual physical and emotional well-being; and 3) a particular orientation to values that preserve self worth, such as a focus on ability and supporting autonomy and decision-making (including the right to live with some degree of risk to self) (Wilson, 2007, p.11). Being able to age in place was also a founding vision for AL, but differences in state regulations and funding structures resulted in two approaches to development. For example, on the West coast, Oregon negotiated a government-subsidized "living center with assistance" to provide an alternate level

of care, including some medical and health related supports, for older adults who did not need to live in a full nursing home, while on the East coast, privately owned AL facilities also provided an alternative to nursing homes, but state restrictions limited the tenancy of residents with more complex medical or physical limitations (Wilson, 2007, p. 13). As a result, private facilities tended not to develop in-house services and instead helped families arrange for additional care, until lack of finances or additional resources necessitated a move to a nursing home (Wilson, 2007, p. 13). These two models of AL currently continue to co-exist in the United States.

The development that early advocates could not foresee, however, is that the initial variation in AL models has proliferated further, so that operators use the term 'assisted living' to refer to multiple models of care (Hernandez, 2006; Mollica, 2008; Stone & Reinhardt, 2007) with varying levels of adherence to the original vision of the AL movement (Hernandez, 2006; Wilson, 2007). Ageing in place for example, remains part of the rhetoric of AL in the United States (Chapin & Dobbs-Kemper; 2001; Hernandez, 2006), but instead of simply wrapping services around the person in situ, there are now stratified levels of AL for basic, moderate and high care needs, including some specialized homes that accept persons with dementia (Hernandez, 2006). So, even though there is a common discursive ideal of AL, it appears that a standard type or level of care does not strictly exist in AL in the United States. It also seems that the line between nursing homes and AL may be becoming blurred.

The AL model of housing plus support began to appear in Canada in the early 1990s (McGrail et al., 2012). While the terminology used to describe the levels in the spectrum of Canadian elder care services varies in different provinces and territories (Hollander & Walker, 1998; McGrail et al., 2012), most offer a level called AL, intermediate care, independent living with tenant services, or supportive housing. These labels refer to a congregate housing

arrangement with a level of support that is a middle step between a private home and long term residential care. As with the United States, there are both government-subsidized and privately funded versions of this level of care across the country.

Despite any differences between the historical vision and values of AL and the myriad of ways they have been taken up in international facilities, AL continues to occupy a unique conceptual place in the minds of older adults, somewhere between the ideal of remaining at home and the spectre of fully institutionalized care (Imamoğlu, 2007). Values typically associated with AL are independence, choice, self-direction, and autonomy, which position it as an attractive alternative to traditional residential care models. Although this result is perhaps partly because AL has only emerged in the last several decades and many people have not yet had direct experience with it, this positive image is arguably bolstered by the consumer discourse surrounding AL, which situates it "as one choice in a marketplace where older persons act as rational and informed shoppers, seeking the goods and services that best meet their personal preferences" (Carder & Hernandez, 2004, p. S58).

1.3 AL in British Columbia

I turn now to the growth and development of AL in British Columbia, the province in which this research is set. British Columbia has adopted the language of 'assisted living' and was the first province to regulate AL.[2] To legally call a facility assisted living, operators must register and provide private, lockable suites, with or without cooking facilities, provide five "hospitality services" (meals, housekeeping, laundry, a 24 hour emergency response system and

[2] In BC, both older adults and younger adults with developmental disabilities may reside in housing labelled as AL; in this study I will be focusing strictly on the former.

opportunities for socialization and recreation) and at least one to two "personal assistance services" such as help with activities of daily living[3], taking medications, or monitoring of nutrition (Office of the Assisted Living Registrar, 2009, p. 4-5). The core principles of these residences, as defined by British Columbia's Assisted Living Registrar (2009) are meant to support the "choice, privacy, independence, individuality, dignity and respect" of older adults, as well as their right to live with a degree of risk to self (p.3). Individuals may live in AL as long as their physical care needs do not require 24-hour skilled nursing or exceed a certain amount of care hours per day. An important distinction from some American models is the limit to service levels in British Columbia: individuals who have cognitive impairment to the degree that they might put themselves or others at risk through their actions are not eligible to move to or remain in AL. In addition, ageing in place is not a tenet of AL in this province, and approximately half of those who move to AL will eventually move on to long term residential care because of increased care needs (McGrail et al., 2012).

The growth of AL in British Columbia occurred as part of a provincial restructuring of home and community care services beginning in 2001. The outcome was a series of changes that reduced the hours of both non-medical home support and medical home care available to older adults in the community, saw the closure of 26 publically-funded long term residential care facilities in the province, and restricted entrance eligibility for the remaining long term residential care to only those with "complex" care needs (Cohen, Murphy, Nutland & Ostry, 2005, p. 5-6). Also in the process of restructuring, three tiers of intermediate-level residential care were removed (Cohen, Tate & Baumbusch, 2009), resulting in a service gap for older adults

[3] Dressing, grooming, eating, mobility, and bathing

who needed more assistance than what home care/support could now provide, but not enough to qualify for long term residential care. AL was viewed as a model that would address that gap (Cohen et al., 2009; McGrail et al., 2012).

Critics of the restructuring pointed out several issues related to these changes. First, during the 2001 provincial election campaign, the (victorious) Liberal party promised to build 5,000 subsidized long term residential care beds. Over time, their targets were changed to include AL and supported housing units as comprising over half of the 5,000. The result was an actual reduction of 804 long term care residential care beds between 2001-2008 (Cohen et al.,2009, p.22). Second, at the same time as the cuts to long term residential care, the number of acute care beds in the province was reduced, which resulted in older adults waiting in hospital for long term residential care spaces and people in the community being unable to access acute care beds (Cohen et al., 2005). As I experienced in my time working in the acute care ward with older adults, individuals who were waiting for long term care beds were then pejoratively cast as 'bed blockers', when in fact they were the symptom of a problem rather than the cause. Third, the provincial government justified the prioritizing of AL over long term residential care by suggesting they were listening to public preference over what model of care was more appealing. Yet, because the cost of long term residential care in British Columbia is partially born by the provincial Ministry of Health, critics pointed out that AL saved the government money by shifting costs to the older adults. Although most meals, housekeeping and light personal care are covered in the monthly rate for the current government-subsidized AL (the rate of subsidy is based on income level), the rest of the costs of living remain the responsibility of the individual. So, "the shift to an assisted living model may be more about limiting government's responsibility than about providing 'a homelike atmosphere'" (Cohen et al., 2005, p. 22).

Perhaps at least partially as a result of these changes, research suggests that AL may not actually provide the level of care needed by many older adults who live there: where older adults used to have more gradients of care available via greater provision of home support/care and the levels of intermediate care offered in residential facilities (Cohen et al., 2009), they now appear to arrive in AL at an already high level of care and often must subsequently relocate (Araki, 2004). One study calculated that more than a quarter the people in AL move out of within one year (McGrail et al., 2012).

In spite of these critiques, AL is an increasingly important part of the system of care for older adults in British Columbia. As of 2014, there were 4,422 registered subsidized AL units in the province and 3,213 registered private pay units for a total of 7,635 units (Office of the Seniors Advocate, 2015). In light of the above discussion on the founding philosophy and goals of AL, the current variations in structure, and the controversy around the growth of AL in British Columbia, this model of housing plus support needs to be better understood in terms of its role in health and social care for older adults. The goal of this research is to begin to critically examine the intersection of the philosophies, policies and personal experiences of AL in the context of British Columbia.

1.4 Overview of the chapters

The format of this dissertation follows my research stages of conceptualization, operationalization, investigation, analysis and reflection. Chapter Two provides a conceptual framework for the research in terms of the central theories, discourses, and literature that informed my approach. Understanding some of the assumptions and discourses around ageing, scholarly work on transitions, and the relevant literature on AL was an important grounding from

which to begin my project. The chapter concludes with a statement on the purpose of the research. Chapter Three outlines the methodological approach that structured the project, including research design and analysis. I also address the challenges faced in relation to carrying out the study and my responses to them.

Chapters Four through Seven present the research findings. In Chapter Four I provide an analysis of relevant policy and information documents about AL in British Columbia in order to understand the conceptual and political discourses surrounding it. Chapters Five and Six offer an extended engagement with the relocation narratives of two participants, Rose and Ian. Following this, Chapter Seven synthesizes the major cross-case findings from all the participants alongside the documents and discursive themes discussed in Chapter Four. It also discusses some of the potential influences on the participants' choices in structuring their narratives and highlights the way that participants reference ageing. Finally, Chapter Eight discusses the study's findings in relation to current literature and AL policies, provides recommendations and implications arising from the data, and suggests areas for future research.

1.5 A note on language

In keeping with the emphasis on language and discourse in this paper, it is important to comment on the spelling and terminology used throughout this paper. First, American literature tends to use the spelling 'aging', whereas the UK and other Commonwealth countries tend toward 'ageing.' In this paper, both spellings will be used according to the original spelling in any quoted material and according to my own preference for using 'ageing' in all other cases.

Second, in line with the recent trends in gerontological literature, I will be referring to my participants and to persons of this age demographic as *older adults*. As Putnam (2015, p. 229)

asserts, the term older adult "seems to imply less reduction in individual physical or mental status" than do the terms "elderly adult" or "senior." As with many terms for members of marginalized populations, there is an implied powerlessness or 'othering' inherent in the terms 'elderly' or 'senior'. Adopting the language of older adult is an attempt to recognize that persons of high chronological age do not transform into a separate segment of the population, but remain full members of society.

Chapter 2: Conceptual Context

My interest in exploring older adults' experiences of moving to, and living in, AL began through my own lack of knowledge about what distinguished it from long term residential care and how relocation to it might be different as a result. In order to move to a broader understanding of this phenomenon, I turned to theoretical and research literature related to my specific research interests. As Maxwell (2005) explains, how one makes use of existing scholarship and how one narrows a research focus is related to the researcher's chosen paradigm. Paradigms are "a set of very general philosophical assumptions about the nature of the world (ontology) and how we can understand it (epistemology), assumptions that tend to be shared by researchers working in a specific field or tradition" (p. 36). I therefore begin this chapter with an overview of my guiding paradigms – critical theory and social constructionism. Following this, I present a discussion on the Western discourses of ageing that currently provide a backdrop to our expectations and responses to older adulthood. Finally, I bring in scholarship around transition and life in AL, including a discussion of the current state of research and knowledge in this area. My goal is to demonstrate the rationale for the study and set the framework for the methodological and analytical approaches taken in the course of studying older adults' transitions to AL.

2.1 Guiding paradigms

My approach to this project was informed by two paradigms that share important underpinning values, beliefs, and assumptions, but also have distinct areas of emphasis. Used together, they provide a more complete investigational lens and speak more aptly to my own

ontological and epistemological position. In this section I will outline the aspects of critical theory and social constructionism that informed my research.

2.1.1 Critical theory

Critical theory initially emerged in the 1920s from the Institute for Social Research in Frankfurt, Germany. From its inception, it has been concerned with "how things have come to be the way they are and what they might be in the future...[and] the wider truth or validity of what is currently the case" (How, 2003, p. 3). In other words, existing social structures and relationships have been shaped over time but they are not the only possible ones; through careful reasoning and examination we may find those that are more just or appropriate. So rather than critiquing for its own sake, critical theorists challenge the historical, political, ideological, and economic circumstances that have generated our normative social ideals and oppressive social structures, with the goal of opening up the possibilities for an improved society (How, 2003; Kincheloe & McLaren, 2005). Over time, multiple critical theories have evolved, but a unifying feature among them continues to be the "substitution of power for truth as the primary focus of analysis" (Tallack, 1995, p. 3). For social workers and other researchers interested in issues of power and equity, critical theory offers a paradigm that recognizes the marginalization of different groups and offers a way of linking academia with political action and social change.

2.1.2 Social constructionism

Although social constructionism[4] has variations across different disciplines (i.e. sociology, psychology, linguistics), there are several common interrelated ontological assumptions. First, constructionist social theory proposes that reality, truth, and knowledge about

[4] Although the terms 'constructionist/constructionism' and 'constructivist/constructivism' are closely related and sometimes used interchangeably, I have chosen to use the former terminology to avoid any association with educational psychology, where 'constructivism' is used in relation to learning theory.

our world are not simply existing ‘out there’, inertly waiting to be discovered. It holds that there are certain material constants, but how these constants are named, categorized and responded to is the product of human interpretation. For example, we can see that there is a mountain, but the arbitrary word for it, the legends around it, or significance of it have been constructed by humans. “The goings-on between people in the course of their everyday lives are seen as the practices by which our shared versions of knowledge are constructed” (Burr, 2003, p. 4). By extension, social systems, institutions and practices are not abstract entities exerting influence on human lives, but are comprised of “the actual activities of actual people” (Smith, 2005, p. 54) as they take place over time and space.

Second, social constructionism operates from a critical stance. It urges us to open up “taken-for-granted understandings of the world, including ourselves...and to challenge the view that conventional knowledge is based upon objective, unbiased observation of the world” (Burr, 2003, pp. 2-3). Thus, one of the major areas of focus within social constructionism is the deconstruction and interrogation of language, because it is one of the fundamental ways that social reality and culture are produced (Green, 1983; Habermas, 1983). Deconstruction is the idea that, whatever has been constructed can also be taken apart by exposing the assumptions inherent in a concept “and systems of opposition within it” (Burr, 2003; p. 201). A classic example of this is the binary division of gender and the normative ascriptions we have for ‘men’ and ‘women’. When one considers the great variation that exists *within* genders and the experiences of people who identify as neither, categorizing certain traits or roles as strictly belonging to either men or women is difficult. Gender can therefore be seen as a social construct that does not exist outside of human interpretation. Green (1993, p. 15) makes a similar argument in relation to ageing:

> It follows from the principle that social reality is made in and of language that there is no such extralinguistic thing as aging or the aged (or any other social category). They are rendered realities achieved in linguistic practices of naming, describing, classifying, referencing, and the like, both in ordinary language and specialized discourse.

Third, social constructionism holds that "all ways of understanding are historically and culturally relative" (Burr, 2003, p. 4). The implication of this is that our conceptions of, and responses to, events, customs and practices, social groups, norms, and institutions have shifted over time and will shift again. Woven with our temporal understanding is our cultural interpretation of these phenomena. Part of the critical stance is therefore recognizing that what we accept as fact or truth about something is influenced by the partial nature of our current knowledge about it and by the biases particular to our culture or epoch. Age, for example, has been constructed differently across different cultures and different historical periods, as I discuss in the next section. Because of the multiplicity of standpoints and the shifting context of history, there is not one version of events or one truth about a phenomenon; rather there are multiple ways of knowing and multiple truths. Social constructionism therefore links with critical theory in its position that "knowledge and social action go together" (Burr, 2003, p. 5). By critically interrogating our assumptions about the causes of social problems or injustices, and by recognizing the multiple ways they manifest and are experienced, we can respond with more effective, equitable and creative solutions.

For many social constructionist researchers, these three aspects come together in a focus on discourse and power. Arguably, one of the most influential scholars in this area has been Foucault (Honderich, 1995). Discourse in a Foucaldian sense "refers to a system of possibility for knowledge; or, ways of talking and thinking" (Cheek & Rudge, 1994, p. 584). It is the

storyline we use in reference to a phenomenon; “a systematic, coherent set of images, metaphors and so on that construct an object in a particular way” (Burr, 2003, p. 202). But because different storylines can be told according to different social locations or vantage points, there are a multitude of discourses possible about any one thing. For example, is climate change an elaborate myth or a legitimate threat? What is the definition of a ‘family’?

The question, therefore, is how one story becomes dominant or seen as the ‘true’ version. A Foucauldian perspective proposes that dominant discourses arise from the interplay between historical conditions/contexts and the power of certain groups to influence: “One discourse, or discursive framework, gains prominence at any moment over other discourses by a product of social, political, historical and other structural influences operating on those discourses” (Cheek & Rudge, 1994, p. 584). For example, Foucault’s study of sexuality and medicine has demonstrated how the inherently neutral, disorganized entity of the body has been interpreted according to the values and interests of various historical epochs “to impose categories such as ‘good’ and ‘evil’, ‘natural’ and ‘unnatural’, ‘virtuous’ and ‘sinful’” on bodies and practices (Garner, 2007, p.405). Individual subjects are then defined and treated according to how they meet the criteria for ‘normal’ or desirable bodies and practices; deviance from this norm is marked using labels such as homosexual, disabled, criminal, insane, or sick. This categorization is achieved through the power of those intellectuals and professionals we legitimize as experts – professors, teachers, scientists, doctors, lawyers and bureaucrats, for example – to ‘manufacture’ knowledge and truth by virtue of marginalizing or silencing competing knowledge claims and alternate discourses. To illustrate, in Canada acupuncture is not considered ‘real’ medicine according to the mainstream healthcare system. Despite its use in China for thousands of years, acupuncture in the West has had to undergo scientific testing to gain a modicum of legitimacy

here, and it remains only ‘complementary’ to mainstream Western medicine. “[T]here is a dynamic relationship between power and ‘truth’ where truth is a product of dominant discursive frameworks shaped and defined by power, whilst power is legitimated on the basis of expert ownership of such ‘truth’” (Cheek & Rudge, 1994, p. 585). Western medical professionals and scientists disseminate their truth about medical treatment and operate our medical system, ensuring a cyclical relationship between the generation of ‘truth’ and power.

A key part of analyzing dominant discourses is, therefore, the effect and means of power in their production (Foucault, 1982). Widely cited in critical social science literature, Foucault’s metaphorical application of Bentham’s *Panopticon* to modern social structure speaks to the role of surveillance in upholding dominant discourses. The panopticon is a hypothetical tower constructed so as to allow a supervisor in the centre of the tower to see into the cell of every inmate at all times, “to induce in the inmate a state of conscious and permanent visibility that assures automatic functioning of power” (Foucault, 1977, reprinted in Garner, 2007, p. 415). The supervisor may or may not be present, but the inmate cannot know this and therefore monitors her/his own actions to comply with the expected behaviour and avoid discipline. This metaphor demonstrates how the monitoring of self and others is both a means and an effect of the discursive power of ‘experts’. “It is an important mechanism, for it automatizes and disindividualizes power. Power has its principle not so much in a person as in…an arrangement whose internal mechanisms produce the relation in which individuals are caught up” (Foucault, 1977, reprinted in Garner, 2007, p. 415-416). The power to define ‘knowledge’ is dispersed into omnipresent, anonymous entities so that ‘truths’ about our social world appear natural and incontestable. Importantly, Foucault (1982) also conceptualized resistance as a form of power,

which recognizes the potential of individuals to be active agents and to create alternative discourses.

In the next section, I will draw on social constructionism to critically examine the discourses that have constructed our Western concepts of age and ageing. Through what contexts and processes have they been constructed? What effect does this construction have on our social institutions and personal lives? What are the alternate discourses? Understanding what storylines older adults have to interpret and explain their experiences of ageing, or how these storylines have influenced our system of elder care, is an important backdrop to this study's design and analysis.

2.2 Discourses of ageing

The current conception of 'old age' as a distinct phase of life with unique problems, needs and interests is a modern phenomenon (Gilleard, 2002; Hazan; 1994; Johnson, 2005b; Katz, 2009; Phillipson, 1998). The roots of such thinking can be traced back to the Enlightenment, which heralded a transition away from religious cosmological thinking. Until this point, humanity was seen as part of a divine universal order. With the advancement of scientific methods and equipment that enabled more of the earth and the heavens to be discovered than ever before, Western thinking began to reflect the notion that humanity could 'step outside' nature and "handle [it] from a point in the universe outside the earth" (Arendt, 1958/1998, p.262). Freed from the bounds of religious interpretation, scientists began to configure a new order of the world based on human perception, detached rationality, and observation. This order was applied successively to the physical world as well as human society, and helped to replace the cyclical conception of life with "one modelled on a rising and descending staircase"

(Johnson, 2005b, p. 565). The continued growth and dominance of the scientific paradigm and its focus on "calculation, division and hierarchy" (Katz, 2009, p.32) arguably recast age as something other than an accepted part of the life cycle. Later, the advent of industrialization and capitalism helped to increasingly define and shape the borders of ageing and the aged.

Today in mainstream Western society, ageing is typically approached in terms of a 'problem' to be solved or managed. According to critical and social constructionist theory however, any problems are not inherent in ageing itself; rather, they are the result of a particular way of conceptualizing and responding to age. Three main discourses currently form the basis of policies and programs for older adults: biomedical, economic, and successful ageing.

2.2.1 The biomedical discourse of ageing

"The biomedical model both colonizes notions of old age and reinforces ageist social prejudices to the extent that infirmity and decline stand for the process of aging itself and medicine its potential saviour" (Powell & Longino, 2001, p. 201). It is an inherently negative discourse focused on the physical aspects of ageing, which are framed in terms of pathology, burden, disease, and deficit. Advances in research and treatment for medical conditions commonly associated with ageing are, of course, positive in many respects. They support older adults to maintain independence, preferred lifestyles and favourite activities. The difficulty with the biomedical discourse is that it often mutes alternative conceptualizations of age and ageing. Its dominance in Western society means that ageing is viewed primarily as a trajectory of decline until death, rather than an important life process, a subjective experience, or the signifier for a new social role.

The development of the biomedical discourse began in the first part of the twentieth century, when biological scientists began to apply their knowledge to the phenomenon of ageing.

Their work "melded basic research about aging with practical suggestions for the aged" (Hendricks & Achenbaum, 1999, p. 26) and marked the emergence of traditional gerontology and its focus on the 'problems' of age. "Indeed, the whole field was developed originally by physicians who were concerned about the impact of chronic diseases and the pathologies of later life" (Johnson, 2005a, p. xxiii). While gerontology later expanded to include social and cultural aspects of ageing, "most gerontological research in recent decades has focused on the functional problems of aged populations, seen in human terms as medical disability or barriers to independent living" (Bengston, Putney & Johnson, 2005, p. 4). Critics have pointed to the role of funding and research priorities set at institutional and governmental levels, which continue to prioritize biomedical goals and functional 'solutions' to the problems of ageing (Estes & Binney, 1989; Johnson, 2005a).

The resulting construction of ageing by 'experts' as a functional or medical problem has influenced both the conceptualization of ageing in general as well as what Estes and Binney (1989) call "the praxis of aging" – the "behaviors and policies growing out of thinking of aging as a medical problem" (p. 587). For example, services for older adults are most often located within the medical system and typically prioritize medical monitoring and physical maintenance over socio-emotional support or activity (Cohen et al., 2006; Diamond, 1992; Ronch, 2004). This means that housing or support services often have deficit-based criteria that *require* older adults to have poor physical health or functioning, and also that programs for non-medical needs like recreation or socializing are understaffed and underfunded. At a social level, the power of the biomedical discourse creates a 'buy in' from the lay public that "the problems of aging are primarily biological and physiological" rather than the outcome of social inequality or structural

barriers (Estes & Binney, 1989). This in turn legitimizes policies and programs for older adults that focus primarily on health and medical monitoring rather than social needs.

Another example of the influence of the biomedical discourse is how the everyday definition of 'care' has been separated from its relational and familial context and is instead equated with medical treatment and monitoring (Green, 1993). Research suggests that family members feel moral pressure to pursue complex medical treatments for relations in their 80s and 90s as expressions of care and love (Kaufman, Shim and Russ, 2004). This is not to assert that it is right or wrong to pursue such treatments for older adults, but to demonstrate that medical intervention has been elevated to the point where it is "normalized as necessary and appropriate. Medicine today is considered the right (and perhaps the only) tool for managing the problems of aging" (Kaufman, et al., 2004, p.731). As a result, older people and their families have learned "to interpret their problems and anxieties increasingly through the medium of doctors in general and drugs in particular" (Phillipson, 1998, p. 34).

The biomedical discourse also has an influence on individual expectations and experiences of ageing. In particular, the positioning of physicians and other healthcare professionals as experts in 'care' subordinates older adults and their own knowledge. For example, the specialized language of medicine means that, when making decisions for treatment within the medical system, older adults can face difficulty expressing their preferences and feelings in a way that doctors will understand and accept, because they "lack an adequate idiom" (Kunneman, 1997, p. 281). They must struggle to translate their point of view into the rational language of medicine in order to continue the conversation. As well, the privileging of expert knowledge also means that physicians and other health care professionals are positioned as gatekeepers to an array of services such as home support, day programs, respite care, specialized

transportation, etc. In order to access these services, older adults must submit to medical assessments, a practice which Powell and Biggs (2000) have linked to the Foucauldian concept of surveillance. For example, older adults are made aware that there are service eligibility requirements but these are not always explicit; potential service users must allow themselves to fall under the gaze of those in power in the hope of receiving (and continuing to receive) these services. Using decontextualized measures of function and health as determinants for access to services is useful in rationing limited resources, because it sidesteps issues of social inequality and in effect places responsibility for receiving services (or not) within the individual's own body.

2.2.2 The economic discourse(s) of ageing

The biomedical model of ageing is linked to another dominant discourse in Canada and other Western welfare states, which frames older adults as economic liabilities. The 'inevitable' infirmity and poor health of old age, in combination with the retired status of older people and the population ageing associated with the baby boom generation have created a discourse described in various terms including 'alarmist', 'voodoo', or 'apocalyptic' demography (Gee, 2000; Katz, 2009; Rozanova, Herbert & McDaniel, 2006). It is

> ... the oversimplified idea that population aging has catastrophic consequences for a society. More specifically, it embraces the view that increasing numbers (or 'hordes') of older people will bankrupt a society, due to their incessant demands on the health care system and on public pensions. (Gee, 2000, p. 5)

Popular media contributes to the perception of the ageing population as an economic burden. Both Gee (2000) and Rozanova et al. (2006) reviewed Canadian newspapers and found that apocalyptic demography is a prevalent discursive theme in the stories about older Canadians.

This discourse is closely tied to the biomedical discourse of ageing: “Seniors, even if healthy at the moment, were portrayed as a time bomb that would sooner or later damage society due to the rising costs of the health care system” (Rozanova et al. 2006, p. 381). Such predictions rely heavily on dependency ratios, which Gee (2000; 2002) has criticized because they arbitrarily equate certain age groups with non-labour market status and define ‘dependence’ according to narrow economic criteria and a stereotypical construction of idle, unhealthy older adults. The dependency ratio is simply a measure of those who are considered to be out of the workforce (those under 20 and over 65), compared against those of working age. Those who are not in the workforce are assumed to be users of health care and social welfare benefits, rather than contributors. However, this measure does not capture the reality (and socioeconomic value) of many older adults who are retiring later (Carrière & Galarneau, 2011) or those who provide important unpaid labour such as childcare (Geurts, Van Tilberg, Poortman, & Dykstra, 2015; Gray, 2005) or community service (Wiles & Jayasinha, 2013).

Further, from political economy and moral economy perspectives, this overlooks the major role that the state has had in shaping the social identity of older adults and the expectations of retirement (Estes, 1999; Kohli, 1987). In feudal times, impoverished older adults received charity as part of a group defined as the ‘deserving poor’ under Elizabethan Poor Laws. In this period they were not identified as having unique considerations or status based on age, but on being able-bodied or not (Gilleard, 2002). Different models of social insurance and social pensions for older adults began developing in the latter part of the 19th century. Germany, for example, initiated a social insurance scheme in the 1880s that was financed by contributions made by workers during their employment. Within the next decade, Iceland, Denmark, New Zealand, Australia and the UK had introduced non-contributory social pensions, and Sweden had

initiated both social insurance and social pensions by 1913 (Palacios & Knox-Vydmanov, 2014). Payments were low, however, so many older workers continued working as long as possible or relied on family support as a supplement (Palacios & Knox-Vydmanov, 2014; Phillipson, 1998).

In the post-world war period of the 1950s, industrialized nations began to develop an integrated, state-run system of income redistribution, including both contributory social insurance and non-contributory pensions. In part this was due to the recognition that state intervention was necessary to protect the stability of employment and the economy against crises like the Great Depression (Armitage, 1996). Older workers needed to be encouraged to leave the workforce and open up positions for younger workers; they therefore required a guaranteed minimum income. Using the example of Germany, Kohli (1987, p. 129) proposes the evolution of retirement and pensions was part of an effort to organize the lifecourse to meet the demands of the capitalist economy, specifically into periods of "preparation 'activity', and retirement...The emergence of retirement ...meant the emergence of old age as a distinct life phase, structurally set apart from active life and with a clear chronological boundary." Over time, the restructuring became imbued with moral undertones of fairness and reciprocity, with the state being seen as providing protection against the risks that could interfere with paid work such as illness, disability and old age. This model became common in Western states, where retirement symbolized "a fair exchange for past work and services" (Phillipson, 1998, p. 120).

As arbitrary chronological age became associated with retirement age and lifespans continued to lengthen, retirement and older adulthood came to be seen as a distinct 'third age' of human development that offered older adults the opportunity for a new social identity and fulfillment beyond the workplace (Phillipson, 1998). Although public pension amounts have historically been set close to minimum income levels and have been eroding since the 1970s

(Phillipson, 1998), the idea of the third age has fostered a stereotypical image of retirees as spending their pensions on carefree, consumerist lifestyles. Self-improvement, activity, "sunbelt" and "snowbird" lifestyles, and even higher education have since become idealized retirement pursuits and have supported a lucrative seniors' industry (Katz, 2009).

The economic discourse of older adults is homogenizing and paradoxical as a result. On the one hand, older adults have been constructed as a discrete social unit, seen as 'deserving' of pensions and social benefits by virtue of chronological age and presumed participation in the paid workforce. Yet the stereotype of older adults as being able to afford a 'third age lifestyle' at the same time as they are drawing public pension money seems to indicate that they are taking more than their share – apocalyptic demography asserts that there will not be enough in the government coffers to support the generations after the 'grey wave' of baby boomers has plundered them for health care and pension costs.

This discourse is damaging for several reasons. First, by referencing ageing solely in terms of financial costs, it fails to recognize the intergenerational social capital of older adults and perpetuates the association of age with dependence. While older adults are being recognized for past contributions, it still does not present a valuation of age in and of itself, which means that women who worked (and continue to work) in the home, those with disabilities, or those with tenuous connections to the workforce are not extended this social worth. Second, it can create a sense of failure or dissatisfaction for those who cannot afford the idealized image of retirement. In Canada, for example, the median income for individuals 65 and above is only $26, 990 (Statistics Canada, 2017), meaning that a 'third age lifestyle' is out of reach for a significant number of older Canadians. This links to a third issue, which is that, similar to biomedical discourse, the economic discourse individualizes the responsibility for how one

experiences ageing (Estes, 1999). There is no recognition of the cumulative effects of capitalist class stratification or social inequality that occur over a lifetime and which influence levels of health, savings, and private pension income at the time of retirement. Individuals with lifelong economic disadvantage typically enter retirement with low economic and social status; the process of retirement or the fact of being 'old' does not in itself create dependence (Walker, 1981). Similarly, the conceptual framework for the social determinants of health developed by the World Health Organization (2010) describes a complex set of political, structural, environmental and psychosocial and behavioural factors that interact to influence health, including the structure of the available health system itself. Differential access to health care based on geography or social policy; social and economic marginalization based on race, gender and ability that affects education, occupation and material wealth; political ideology influencing health care policy; and material factors like quality of food and housing act together across a lifespan to influence health even before individuals enter old age. Yet in using the state benefits to which they are entitled, older adults are singled out as unusual or problematic.

2.2.3 The discourse of successful ageing

The discursive constructions of ageing as medical and economic problems, as well as the ideals of the third age, come together in a third discourse of 'successful' ageing. Currently there is no clear consensus within the gerontology on the definition or scope of the term (Cosco, Prina, Perales, Stephan & Brayne, 2014; Jacobs, 2005; Pruchno, Wilson-Genderson, Rose & Cartwright, 2010). However, literature suggests that it began gaining in popularity after Rowe and Kahn's 1987 publication on the distinction between "usual" and "successful" aging, and their 1997 publication on "the three key components of successful ageing: the avoidance of disease and disability, the maintenance of cognitive and physical function, and social

engagement" (Martinson & Berridge, 2015, p. 59). These areas continue to be fundamental to the construct of successful ageing. Research in the following decades has attempted to find ways to measure successful ageing and identify both subjective and objective factors (Pruchno et al., 2010), as well as to address theoretical shortcomings such as lack of input from older adults or cultural variability (Martinson & Berridge, 2015).

The idea of an active, engaged, healthy old age is undoubtedly an improvement on the negative stereotypes of isolated, passive, depressed, unhealthy older adults that still dominate the public imagination (Abramson & Silverstein, 2006; Tornstam, 2007; Weicht, 2013). But there are several issues around the notion that one can age 'successfully'. First, the associated features of what success looks like are arbitrary and illogical. From a social constructionist perspective, "old age is created conceptually, through picking out particular features and defining them as...constituting oldness" (Overall, 2006, p. 131). In line with the biomedical discourse of ageing, research with older adults has shown that the features most often associated with identifying as 'old' have to do with physical decline and dependence (Degnen, 2007; Clarke, 2000; Hurd, 1999; Nilsson, Sarvimaki & Ekman, 1999). Yet equation of ageing with disability is problematic. For example, it does not recognize the experience of individuals with life-long physical disabilities, who have already faced adaptations to identity and activity that are not necessarily linked to age (Cooper & Bigby, 2014). As well, it creates a logical fallacy: since some degree of decline is inevitable as one ages, the only way to be 'successful' at ageing appears to be "not to age at all" (Andrews, 1999, p. 305). As a result, the label of 'old' is pushed into a higher age bracket, where

> the oldest old …(are expected to) conform to the traditional roles of old age and a new phase of 'young elderly' are inserted into the lifecourse. In that way, instead of

deconstructing standardized age roles…traditional old age roles are shifted towards higher age groups. (Jacobs, 2005, p. 2)

Second, the normative values placed on aging 'properly' are also problematic: "terms such as successful aging are not neutral; they are laden with comparative, either-or, hierarchically ordered dimensions" (Holstein and Minkler, 2003, p. 791). So, although it seems to frame ageing in a more positive way, the binary terms of success verses failure actually "map onto... the decline-and-loss model of yesterday...These dichotomies are arguably two sides of the same judgmental coin" (Martison & Berridge, 2015, p. 67).

As such, successful ageing does not necessarily counter ageism or internalized ageism. A recent study by Calasanti (2016) explored whether the pervasive discourse of successful ageing resonated with middle-aged participants, whether they viewed it as attainable, and whether it had "lessened their fears about aging, decline, negative stereotypes and exclusion" for their future aged selves (p.1094). In instances where the participants felt they could not control the ageing process, they reported feeling stress, tension and fear. "Rather than supplanting the later-life disease and decline rhetoric, the successful aging paradigm simply became another discourse that existed in tandem with it. In this sense, ageism was not challenged so much as displaced, redefined, and perhaps intensified" (p.1099).

Ageism also appears intragenerationally, where 'oldness' is passed as a judgement on those who fail to age successfully. For example, during Degnen's (2007) ethnography in a village in Britain, she found that her older adult participants monitored their peers and enacted social sanctions on those who displayed signs of ageing. One community member, Mrs. Atherton, was the subject of several conversations related to her disruptive behaviour, which was blamed specifically on observed characteristics that marked her as "old." "Through this process

...both between individuals and as a group, consensus is reaffirmed about Mrs. Atherton, who is stigmatised (sic) as a marginal figure, worthy of ostracisation ('We just ignored her') due to her unacceptably high levels of oldness" (p.75). In public meeting places generally, Dengen observed that community members paid "a great deal of attention" to how others appeared, "both physically and mentally" on different occasions. "Any perceived decline in others then becomes public property for the gossip circuit" and might then influence the "community code" around that individual (p.76). As Dengen discusses, her findings show how the Foucauldian concepts of surveillance, discipline, and governmentality operate on individual and social levels and serve to uphold normative bodily ideals.

The above examples also demonstrate a third critique of the discourse of successful ageing, which is that it strongly promotes individualized management of the ageing process. Research with older adults reflects this rhetoric; in one of her studies with older women Hurd (1999) found that, "without exception, [those identifying as] 'not old' profess a defiant refusal to slow down, a firm belief in the power of activity, and a conviction that their own lifestyle choices are what separate them from the 'old' (p. 430). Rudman (2015) studied the narratives of older adults preparing for and living in retirement and noted an intersection of positive ageing discourses with neoliberal values such as personal responsibility. Persons seen to be not ageing 'well' (including themselves) were judged as failing to take care of their bodies properly. In their study on the portrayal of ageing in the *Globe and Mail* newspaper, Rozanova et al. (2006) found that "successful aging was, indeed, the major discursive theme in the stories of older adults", and that "overall, it was subtly suggested that older adults might have agency in determining the quality of their lives, through personal choices made earlier and in the present" (p. 379). Similar to the media coverage of older adults and their (over)use of health care and public pension

money, the researchers in this study observed that discussion of structural factors such as poverty, lack of community resources, or access to health care that affect the ageing experience was missing from the articles. In the absence of such a discussion, the implicit conclusion is that those who 'fail' to meet the standards of successful ageing (health, vitality, and youthfulness) have only themselves to blame. Subsequent studies of the *Globe and Mail* reaffirmed the messages of "successful aging is a personal choice" and "individual responsibility for unsuccessful aging" (Rozanova, 2010). Interestingly, when Rozanova and colleagues studied the media depictions of nursing home residents in the United States, they found that "retaining purchasing power", both in terms of purchasing care and in terms of having spending money, was a form of autonomy that supported a notion of successful ageing even in the fourth age of physical frailty (Rozanova, Miller & Wetle, 2014). This finding again points to the discourse of individual (economic) responsibility for one's ageing trajectory.

At a policy level, the language and rhetoric of successful ageing have been incorporated into governmental approaches to ageing in Canada and other industrialized welfare states (Katz, 2009; Lassen & Moreira, 2014; Special Senate Committee on Aging 2007, 2008; Struthers, 2013). Arguably, this is at least partly because successful/active ageing is useful in shifting the financial and social responsibility for the aged onto older adults themselves (Katz, 2009). Typically, models of successful ageing promoted by governments draw from health promotion strategies on "prevention and individually modifiable…behaviours" (Harris, 2008, p. 44) for the purposes of delaying or mitigating the 'problems' of ageing. As an example, the official provincial website for older adults in British Columbia has a dedicated 'Active Living' page where it promotes health-based advice, internet links, and policy reports (http://www2.gov.bc.ca/gov/content/family-social-supports/seniors/health-safety/active-aging).

While much of the advice offered is applicable across the lifespan (exercise, healthy eating and social activity), the rhetoric of active ageing recasts them here as strategies specifically helpful to older adults. A statement on why the province supports this approach makes a clear link to other problem-based ageing discourses: "Active, healthy aging helps reduce the pressure on health care and social services."

Like the biomedical and economic discourses of ageing, 'successful ageing' is also a product of a particular era. Katz (2009) suggests that the current postmodern values of "timelessness…speed, impermanence and immortality" mesh well with "the neoliberal dream of the end of state-supported dependency" (p. 18) because each ascribe to increased individual choice and a decreased significance of traditional social categories such as age. Further, it ties in to the modern notion of a third age, where the 'young old' enjoy retirement by pursuing leisure activities and focusing on individualistic priorities. Economically, successful ageing is a useful discourse because it justifies reduced spending on seniors' benefits at the same time as it drives a seniors' niche market (Katz, 2009). We are also at a historical point where the baby boom generation, who spurred the initial development of youth marketing and youth culture (Friedan, 1993), is entering old age. Conceivably, these individuals will accept and perpetuate the youthful doctrine of successful ageing because they have been surrounded by youthful ideals throughout their lives. The idea of successful ageing is also congruent with the American dream of "the unlimited right to individual self realization" (Hazan, 1994, p. 48) and the liberal values of autonomy and independence (Nedelsky, 1989). Finally, the discourse of successful ageing may be particularly appealing in this secular era where old age is simply a symbolic marker of a transition towards death without any particular cultural status or function (Hazan, 1994). Lacking positive alternatives, older adults may struggle to maintain a middle-aged identity.

To summarize, the biomedical, economic and successful ageing discourses construct ageing as a problem to be managed. Using Foucault's concept of 'problemetization' Katz (2009) states: "problemetizing practices discipline everyday life by transforming ordinary and sometimes arbitrary aspects of human existence – such as adjustment to retirement – into universal dilemmas that call for administrative and professional interventions buoyed by a politics of 'thought'" (p. 124). The discursive connection of passivity, decline and dependence to old age serves to justify the work of gerontologists, social workers, case managers, geriatricians, care homes and professional carers who form the "oldhood industry" (McKnight, 1995, p. 31). While it is undeniable that people experience changes in their bodies and lifestyles as they age, there are alternate ways of discussing and conceiving the experience of ageing that can accommodate this reality while challenging the portrayal of ageing as simply problematic.

2.2.4 An alternative discourse of ageing

In the past, one of the criticisms of mainstream gerontology was that it participated "in the economic and political construction of the issues and 'problems' that are associated with old age" (Lassen &Moreira, 2014, p.33. But a growing body of research and literature that draws on critical and constructionist theory challenges the overly negative and empirical aspects of this traditional approach. In particular, it seeks to introduce multiple voices and perspectives into our understanding of ageing, especially those of marginalized or oppressed populations (Clarke, 2001; Overall, 2006; Segal, 2007) and to recognize structural and discursive influences that differently shape individual and collective expectations for, and experiences of, later life. Specifically, it critiques the inadequacy of objective, scientific language to express individual, embodied experiences (Kunneman, 1997) and asserts that ageing is individually interpreted against a backdrop of cultural and social discourses, institutions, practices, and assumptions

(Hazan, 1994; Rudman; 2015). Further, it promotes a contextual knowledge of ageing that is shaped by social location and experience across the life span (Gubrium, 1993) and does not seek to impose unifying, macro-level theory onto its variegated form. A common goal of this alternate approach is to recognize the diversity of the ageing experience and open a conceptual space where older people themselves can influence the discourse of ageing and the collective identity of older adults (Katz, 2009; Zimmerman & Grebe, 2014).

Much of the work in this area is multitheoretical and resists categorization into a specific, bounded discourse because it does not aspire to monolithic 'truth' about ageing. However, there are several common themes that together challenge the assumptions of the dominant construction of ageing. First, an alternative discourse of ageing asserts that whatever 'old age' is, beyond a certain number of lived chronological years, is culturally and socially defined (including what number of years 'makes' a person old). As such, it cannot be viewed as a homogeneous or universal experience. In particular, the concept of intersectionality, initially developed by Crenshaw (1989), speaks to the idea that individuals who belong to multiple oppressed social groups, such as those based on age, class, dis/ability, gender, ethnicity and race, do not experience discrimination along separate axes of their identity. Rather, these axes intersect in unique and diverse combinations in different contexts, so that individuals can experience compound oppressions at the same time. Importantly, oppressions do not simply overlap, but interact to create an oppression that is something more and different than each type separately. Ageing is, therefore, influenced differentially according to social location such as gender and class (Calasanti & King, 2005), ability (Clarke & Bennett 2013; Overall, 2006) and sexual orientation (Copper, 2015). In addition, changes in historical, social, cultural, political and economic contexts shift the power relationships between different social groups, further

individualizing experiences of oppression (McCall, 2005). This is a relevant point when considering ageing across generations.

Feminist literature offers some of the most developed theory and research with respect to the importance of social location in ageing. This is partly because feminists are beginning to explore their own experiences of ageing (Cruikshank, 2008; Friedan, 1993; hooks, 2002; Ray, 2004; Segal, 2007), and partly because the concepts of social identity, oppression, and the body are traditional territories for feminist investigation. Feminist theorists and researchers assert that gender expectations, particularly standards of attractiveness, strongly influence how women view themselves as they age (Clarke, 2001; Clarke 2011; Clarke & Griffin, 2008; Hurd, 1999). While ageism occurs for both men and women, "women are seen to be 'old' much sooner" (Calasanti, 2005, p. 10) because of the evaluation of a woman's social worth is much more strongly linked to a youthful, sexualized appearance than it is for men. The demographics of ageing are also gendered. The social role of women as caregivers and wives influences their experience of ageing, especially in relation to the likelihood of outliving husbands and the resulting changes in their social and personal identities (Hurd, 1999). As well, women are more likely to experience poverty in old age, because of their tenuous connection to the labour market, statistically lower wages, and resulting difficulty accessing government or private pension plans (Blake, Dean, Kilgano, West & Westlund, 2004). As Cruikshank (2008) argues, lifelong social identities such as gender, or race or sexual orientation are more salient than imposed categorization by age, so it is important that policies and theories de-emphasize 'age' as the unifying category and attempt to reflect the multiplicities of social location.

Second, an alternative discourse of ageing reclaims the body as a complex territory of personal meaning and expression. Traditionally, socially-focused gerontologists have "[handed]

over the study of the aging body to the physiologists and clinicians" (Powell & Longino, 2001, p. 201), which has implicitly supported the dominance of the biomedical discourse of ageing. Critical feminist and constructionist scholars, however, have taken up the study of bodies and embodiment (Clarke, 2011; Clarke & Korotchenko, 2011; Kontos, 2004; Kontos & Martin 2013; Twigg & Buse, 2013), positing that bodies are "simultaneously material *and* constructed" (Calasanti, 2005, p.9, emphasis in original). The concept of embodiment offers a bridge between objective, physical characteristics of age and the subjective experiences of individuals. It also decentres 'expert' knowledge by foregrounding individual, experiential knowledge. The ageing body is reconceived as a dynamic site of interpretation, control and resistance; the ageing individual is repositioned as an active agent who mediates dominant discourses with individual, contextual knowledge of ageing.

The mediating role of the ageing self has been demonstrated in research. For example, Field-Springer's (2012) narrative research with women who had experienced, or were experiencing menopause demonstrates the complex layers of life experiences and dominant discourses that participants drew on when sharing their experiences of ageing. In some cases ageing narratives were rejected, as in the case of one participant who expressed her "disgust" at the advertising industry for only using slim, young models. In other cases, ageing narratives were incorporated as part of a reidentification of self as an older person, such as the participant who was out with younger co-workers and for the first time realized she was having difficulty climbing stairs. In other research, older adults have been shown to make a conceptual distinction between feeling and being old (Clarke, 2001; Cremin, 1992; Hurd, 1999; Nilsson et al., 2000; Rudman 2015). As noted in the section on successful ageing, feeling old is typically associated with a decline in health or functional ability rather than strict chronological age. Older adults

monitor themselves for these objective markers of age, but when they occur there is a reluctance to accept the label of 'old' for oneself. Instead, some older adults (especially women) foster a Cartesian split between inner and outer selves (Andrews, 1999; Twigg, 2004) in order to "distance themselves from the stereotypes concerning age as well as the physical realities of growing older" (Clarke, 2001, p. 458; also see Clarke, 2011; Hurd, 1999). Although this tactic may be interpreted as a negative reaction to perceived ageing, it does demonstrate the self's interpretive role in rejecting that which does not 'fit' with personal experience, as well as a tacit perception that the dominant discourse of 'age' is not entirely accurate. This assertion is further supported by research showing that 'feeling old' is often used by individuals to describe a temporary state (Cremin, 1992; Clarke, 2001) rather than an irreversible linear progression of decline as promoted by the biomedical discourse of ageing. Similarly, Grenier's work around the concept of frailty revealed that older women made a distinction between 'being' and 'feeling' frail, where being frail was more about "an imposition of a classification that is medical or functional in nature" and feeling frail was related to "social, personal and emotional experiences (e.g. weakness, vulnerability)" (2006, p. 304). Yet even though participants in this study might have accepted the label of 'frail' as a means to access services, they also resisted the marginalized social positioning that comes with the label by rejecting frailty as a personal identity, focusing on their political right to services, and by claiming the label as an act of subversion when it would work to achieve their demands (Grenier & Hanley, 2007). Research also highlights other ways that individuals actively interpret and respond to aging. In some studies older adults used reflexivity, mental strength and individual values to interpret the challenges of ageing as catalysts for existential or spiritual growth (Dalby, 2006; Moore, Metcalf and Schow, 2006); in other cases they adopted a stance of "senior coolness" to counter dominant

narratives of dependence or helplessness (Zimmerman & Grebe, 2014). An alternative discourse of ageing therefore directs attention to the role of the embodied self in responding and reacting to ageing in personally meaningful ways. It creates a space for older adults to provide their own interpretation of ageing that may resist the discourse of decline and dependence.

Third, an alternative discourse of ageing stresses interdependence rather than independence. Biomedical, apocalyptic demography, and successful ageing discourses share a common vilification of the 'dependence' of old age. As some scholars have noted, the concept of 'dependency' has variations in meaning, but the connotations are "almost entirely negative" (Fine and Glendinning, 2005, p. 605). In Western liberal discourse, dependence is positioned as the binary opposite to the closely related concepts of autonomy and independence. Autonomy is equated with free will, self-determination, and non-interference from others (Agich, 2003; Nedelsky, 1989). The independent individual is valorized as "atomistic" (Nedelsky, 1989, p. 8) and makes rational decisions independently of external influences. Being seen as dependent therefore puts older adults in a stigmatized and powerless role, something which is reinforced by our system of elder care (Agich, 2003). Yet older adults who avoid help-seeking in an effort to remain independent can instead face isolation (Plath, 2008). Scholars coming from feminist, critical, and constructionist and perspectives have critiqued the dominant interpretation of independence and autonomy, pointing out that it overlooks the actual, discursive process of decision-making and the reality of the social world.

> If we ask ourselves what actually enables people to be autonomous, the answer is not isolation, but relationships…that provide support and guidance for the development and experience of autonomy…We see that relatedness is not, as our tradition teaches,

> the antithesis of autonomy, but a literal precondition of autonomy, and interdependence a constant component of autonomy. (Nedelsky 1989, p. 12)

There are two points to highlight in this quote. First, autonomy is not impeded or extinguished by being in relationship with others. We are rely on each other from birth for affection, security, and, as Arendt (1958/1998) asserts, to bring us into the social world as individuals by witnessing and naming our actions. Further, "some of our most essential characteristics, such as our capacity for language and the conceptual framework through which we see the world, are not made by us but given to us (or developed in us) through our interactions with others" (Nedelsky, 1989, p.8). Second, the notion of *inter*dependence speaks to the continuous back-and-forth of independence and dependence within these relationships; people are never exclusively one or the other. 'Dependence' is therefore not an inherently negative term, nor is it the particular domain of old age. Further, one can experience aspects dependence while, at the same time, continuing to grow and develop in other ways (Tornstam, 2011).

The adoption of care approaches based in relational ethics (Bergum & Dosseter, 2005; Gadow, 2006; Gilligan 1987/1995), relational capacity (Hartrick, 1997) and ethics of care (Tronto, 1993; Barnes & Brannelly, 2008) has been proposed as a way of redressing the strict binary of dependence/independence and the accompanying power imbalance. In general, this type of approach

> recognizes that we are all givers and receivers of care at different times; it is not linked to gender or 'women's work'; it acknowledges bodily, spiritual and material aspects, the perspectives of caregivers and care receivers, the existence of power and conflict within care, and the moral dimension of care. (Barnes and Brannelly, 2008, p. 385)

While still marginalized in mainstream health care settings and services for older adults, such an approach does offer new possibilities for conceptualizing care in term of human rights rather than a biomedical burden. As an example, researchers have begun to develop social, cultural and even citizenship-based models of care for dementia (O'Connor et al., 2007; Bartlett & O'Connor, 2007), an area long dominated by the search for drugs to treat or cure.

Taken together, the concepts of social location, embodiment, and interdependence as embraced in an alternate discourse of ageing do not deny the physical fact of senescence or the challenges it presents to older adults. Rather, they broaden the perspective of ageing by asserting that it is an experience, not a problem, and that it involves a complex mingling of physical and social, political, cultural, structural, subjective and interpersonal aspects. Older adults are not a homogeneous social group unto themselves, but they do have particular needs and perspectives. Change and continuity "exist simultaneously" in older people and researchers "must find a way to locate and represent both" (Andrews, 1999, p. 313).

2.2.5 Section summary

To summarize, the biomedical, economic, successful ageing discourses discussed in this section demonstrate the critical and social constructionist position that the Western concept of old age does not exist outside of historical, political and economic context. The primacy of scientific and capitalist discourses has influenced the way ageing and old age have been interpreted and positioned; namely, as a problem that can be solved by medical or economic measures. Ageing has also been imbued with the rhetoric of personal responsibility and control, as the discourse of successful ageing tasks older adults with the impossible project of avoiding decline. The alternative discourse of ageing being developed by critical gerontologists in the literature has been useful in challenging these messages and offering a different lens that

recognizes subjective, embodied, heterogeneous ways of experiencing age, as well as the positive potential for this stage of life.

These different discourses of ageing provide important groundwork for this study about older adults' relocation to AL. On one level, they help set the stage for research investigating how individuals experience the transition from life in their own, mostly individually-directed environments to the congregate environment of AL with its organizational authority: I needed to be familiar with the storylines participants might draw on in describing this experience, such as the biomedical discourse of the health care system in which AL is located, wider social expectations of ageing, and personal resistance. On another level, they focus attention on how different influences have shaped our system of care for older adults. The dominant concept of dependence, for example, underpins the current model of long term residential care and was part of the impetus to create a more independent model called AL. Making the connection between discourse and practice was a fundamental step towards critically investigating whether AL has lived up to its own founding philosophy of care.

2.3 Transition

Despite the debate among scholars and theorists about how to conceptualize old age, there is agreement on at least one point: ageing brings with it an expectation of change. Change in social roles, health, financial status, and even perspectives on life are only some of the possible changes that one may experience as part of ageing. Further, many of these changes are interrelated and precipitate larger personal transitions, particularly changes in health or ability that result in a move to formal residential care.

For example, Litwak and Longino's (1987) often-cited model of migration patterns of the elderly describes three types of moves initiated after certain late life events and illustrates the link between health and living accommodations. The first is a comfort or amenities-based move following retirement, often to places such as vacation or retirement communities. The second type of move is made to be in closer proximity to children, whereby familial commitment provides a level of informal support that allows the older adult to continue to live in his or her home. It is typically related to an experience (or anticipation) of disability or difficulty with daily activities, either in self or spouse. It can also coincide with widowhood, where the spouse who provided either help with, or motivation for, household tasks is no longer present. The third type of move, to a more formalized care environment or residential care home (including an AL facility), occurs when the needs of the older adult outstrip the ability of familial network to manage care. Although this particular model of migration is only focused on kin support, it is also the case that relocation to formalized care can be influenced by the availability of community resources and whether they are too expensive or not available/sufficient. Other foundational theories similarly point to the imbalance between an older person and their environment that can result in relocation to formal residential care settings, such as Lawton and Nahemow's (1973) idea of environmental press; or Wiseman's (1980) concept of push-pull factors.

Importantly, these moves represent more than just a change of address – they can generate some of the most deeply felt indicators of ageing. In particular, relocation to a formalized care environment can be a major life event or "turning point" (Cappeliez, Beaupré, & Robitaille, 2008) for individuals. It generally involves the downsizing of possessions, changes in neighbourhoods or communities, disruption to one's social support networks, and adjustment to

the structures and congregate life of a facility. The concept of transition is a useful way to frame this process because of its ability to incorporate temporal, contextual, structural and personal elements into understanding how individuals cope with the changes brought on by relocation. In this section I first explore the theoretical and conceptual aspects of transition before moving into a review of the research related to transition to AL.

2.3.1 Conceptualizing transition

Concepts of transition span the disciplines of psychology, psychiatry, anthropology, sociology, education, gerontology, nursing, geography, and migration studies. A simple definition from geriatric nursing defines transition as "a passage between two relatively stable periods of time" (Schumacher, Jones, & Meleis 1999, p. 2). It is initiated by a break with usual circumstances, understandings, or habits that leads to a period of disorganization and, ultimately, the integration of the change into new and adjusted habits, self concept, or life contexts. A key feature of transition has to do with challenges to self identity that occur during the process (Meleis, 2010, p. 77). As such, "transition occurs over time and entails change and adaptation,…but not all change engages transition" (Kralik, Visentin and Visentin and van Loon, 2006, p.327).

Psychology and sociology have had a major influence in terms of framing transition as an integral part of human development and linking it to normative ideals of development occurring at particular ages. In gerontological research and practice, these developmental and age-and-stage based theories have been popular in terms of explaining positive/negative responses to life events among older adults. One of the most well-known examples is Erikson's eight-stage model, which originally proposed that the eighth and last stage of life involved the struggle of ego integrity versus despair. In this stage, one looks back at one's life and can either

find a sense of reconciliation and satisfaction or is filled with regret (Erikson, 1997). Informed by their own experiences of ageing, Erikson and his wife later developed an additional stage based on interviews with older adults. In the ninth stage, individuals deal again with the developmental tasks and issues of earlier stages, because increasing challenges to their physical function and autonomy result in new conflicts that must be resolved. For example, the primary task of childhood – trust vs. mistrust, is revisited in a new way when individuals are faced with depending on others for help and care (Erikson, 1997). Other age-based theories have linked developmental change to transitional late-life events such as retirement, loss of a spouse, the onset of illness or disability, and the move to formal residential care settings (for example Fisher, 1993). The notion of transition as used in developmental and age-based theories is positive in that it presents even difficult life events as opportunities for personal growth in late life.

However, while transition plays an important part in these theories as the means through which one develops, it is not the actual focus – the goal is to move from one stage to another. As such, transition tends to be conceptualized as a fixed, linear process. An alternate position views it as being comprised of fluid and intersecting experiences across the lifespan that may not always result in a person moving on to a new stage or role (Grenier, 2012). Kralik et al. (2006) have suggested that transition is an "intricate and convoluted process with forward and backward movement", including the possibility to become "stuck" at a given stage (p. 325).

Grenier (2012) has provided several other critiques on how transition has been conceptualized in developmental and age-and-stage theories. First, these theories speak to broad trends in ageing and do not generally recognize the individual heterogeneity of people's lived experiences or the intersecting effects of social location on expectation and opportunity. Different cultural expectations of age-based roles may render these ideas of transition, or what

growth is meant to occur from them, irrelevant. Individuals may also simply reject the conventions of developmental theory, such as the processes of marriage and raising children, yet be extremely satisfied with the trajectory of their lives. Others may have more preoccupying concerns that override normative developmental stages, such as chronic illness, homelessness, or experiences of abuse or trauma. Second, there is less emphasis on the efforts individuals make to maintain continuity in their lives than there is on the perpetual process of change. Older adults do not abandon the habits and identities of a lifetime just by moving into a stage of life that happens to be characterized by things such as relocation or changing physical/mental states. Third, developmental and age-and-stage theories tend to view transition in terms of discrete events that happen to individuals. Similar to the feminist and critical focus on interdependence, an expanded view of transitions recognizes that they are "linked experiences that occur in relationships with the self, family [and] society" (Grenier, 2012, p. 128). A health crisis results in transition for the older adult experiencing it, but also the spouse and/or children who may have to change aspects of their own lives in response.

In reviewing the literature, I found two theoretical frameworks of transition that both responded to the above criticisms and could also be applied to older adults relocating to AL. Both of these frameworks have been developed over several decades through research and professional practice with adults. They share an emphasis on the dynamic and multilayered components of transition itself, rather than considering it as just a means to a larger developmental goal. As well, they provide a framework to explore individual experiences of transition rather than collective trends.

First, Schlossberg's model for counselling adults in transition (1981; 1984) was initiated by evidence from her qualitative interviews that adults experience change across the life course

in variable and unpredictable ways. Her resulting framework synthesized human development theory, life event and transition perspectives, and individual variation theories. As such, the model is not solely focused on older adults, but can address experiences of late life such as retirement, grandparenting, and existential concerns; it has also been revised in recognition of current political contexts and diverse social identities and life experiences (Anderson, Goodman & Schlossberg, 2012). The benefit of this flexibility is that it avoids stereotyping older adults as having uniform characteristics or priorities.

Schlossberg's model draws on aspects of human development theory such as shifts in identity over the lifespan, the continuous project of creating intimacy and relationships, the need for a sense of autonomy, productivity and competence, and desire to belong. But using concepts from ecological theory, the model also considers how the characteristics of the pre- and post-transition environment will act as assets or liabilities in the transition process. This includes the environment of personal and institutional support as well as the physical environment. In addition, transitions are anticipated or unanticipated, occur in specific contexts, and have differing degrees of impact. Transitions can have a positive or negative effect, and there are multiple influencing factors that shape how a person will adapt. For example, an individual's perception of a transition is affected by aspects such as resulting role changes, precipitating events, the timing of the transition in a person's life, control in the process, and any concurrent stresses. Interestingly, Schlossberg also considers "non-events" as influential as well, in the sense that an expected event which did not occur can still trigger a period of disruption. Finally, this model recognizes that individual characteristics will affect the process of transition. These include personal and demographic characteristics (socioeconomic status, age, ethnicity, gender, stage of life, and state of health); psychological resources like personality, outlook and personal

values; and individual coping responses such as creation of meaning, information-seeking and plan-making, proactive or inhibited action, and stress responses (Schlossberg, 1984, p. 108).

A second theoretical framework, developed by Meleis and Schumacher and colleagues (Meleis, 2010; Meleis, Sawyer, Im, Messias, & Schumacher, 2000; Schumacher & Melies, 1994), resulted from the need for a model of transition in nursing, where so much of the profession's work takes place with individuals experiencing change and its accompanying uncertainty. It is relevant in exploring older adults' relocation to AL because the pathway to AL is often through the healthcare system or related to changes in health, and also because the model has been applied to working with older adults (Meleis, 2010; Rossen & Knafl, 2003; Schumacher, Meleis & Jones, 1999). This framework involves several interrelated components, beginning with an acknowledgement that there are different types and patterns of transition, such as developmental, situational, health or illness-related, and organizational (environmental). These transitions can occur simultaneously or sequentially with related or unrelated effects. Importantly, this conceptualization recognizes that the transition of one person can have effects on others such as family members.

A second component incorporates the various factors and influences surrounding the transition such as awareness and engagement of an individual in the process, the perceived importance the changes have for the individual, the timing and duration of transition, and social/personal norms that influence how they are interpreted. The model acknowledges that some transitions such as integration into a new culture can take years and never truly be 'finished'. Transitions can also have critical developments and turning points within them, which are an integral part of the overall process. For example, a person might be newly relocated to AL,

but then experience hospitalization which would interrupt the process of settling in or redirect how it proceeds.

The third component of this theory is the idea that there are facilitators and inhibitors to transition. These can be personal in nature, such as the meaning ascribed to events, cultural beliefs, the degree of preparation and knowledge a person has prior to the transition, and socioeconomic status. At a larger level, community and social conditions can act as facilitators or inhibitors in terms of the degree of stigma or social support associated with a transition. Moving to AL, according to this theory, might hold fewer stigmas than living in long term residential care where the dominant discourse positions residents as 'frail' or 'dependent'.

The last component of the theory is what the authors describe as "patterns of response". Feeling connected, interacting with caring others, making comparisons between the old and the new, and developing self confidence in the new context are thought to be indicators that a person is actively in the process of transition. As an outcome of transition, individuals often display or express a mastery of new skills and a reintegrated identity. The goal of this multifaceted theory is to provide a framework with which to understand and evaluate particular components of transition and to initiate appropriately targeted interventions.

Combined, Schlossberg's and Meleis et al.'s frameworks speak to the importance of objective and subjective factors in the process of transition, as well as the complex array of influences that provide each individual with a unique experience of similar events. They reflect the reality that transitions are not always 'complete' or linear. In this way, there is less emphasis on an objective marker of 'success' in transition – the end point is instead related to an individual's own sense of reintegration after a period of disruption. As well, the models account for multiple, interrelated transitions, which reflect the reality of how life events often manifest,

especially in terms of health related changes that result in a change of residence, or the ripple effects on families when a member is moving to AL. Importantly, they recognize that, while many changes of older adulthood involve loss, they can also bring opportunity. Finally, from a constructionist perspective, the frameworks contain elements that incorporate the influence of wider social discourses and institutions on individual expectations of ageing and on our age-related polices.

My purpose in exploring the theories and conceptualizations of transition was to prepare for reading the substantive research on moving to AL and to be aware of the ways that my participants might speak about their relocation and process of settling in. What I noticed when reviewing the literature around moving to, and living in, formal residential care settings was that, although various individual components of transition suggested by the above frameworks are reflected in the research, there are few open-ended inquiries into the process of transition as a whole. Instead, research tends to highlight some discrete areas that the frameworks have identified as influential, such as the personal and structural context of relocation, organizational features in the residential care facility that support or inhibit resident satisfaction, or the role of interpersonal factors such as relationships. Arguably each of these areas is worthy of investigation, but it remains important to hear holistic accounts of transition during relocation because of the complex and individual nature of the phenomenon. Keeping this critique in mind, I turn now to a discussion of the research around older adults and transition to AL.

2.3.2 Transition to AL in the literature

Preliminary literature searches revealed that research specifically on the experience of relocating to AL is a relatively small body of literature; the body of Canadian research on the topic is smaller yet. I therefore broadened my search, using both Medline (Ovid) and Academic

Search Complete data bases and the terms ‘older adults or seniors or elderly’ and ‘assisted living or assisted living facilities’ and ‘transition or relocation or move.’ This resulted in just a handful of studies related to the actual transition process; substituting the terms related to transition for terms such as ‘experience or perceptions or attitudes or views’ or omitting them altogether produced results that spoke more broadly to aspects of life and living in AL. Alternately, I removed search terms related to AL and but kept the terms for transition or moving and was able to identify articles about relocation to long term residential care that were informative.

There are several observations to be made about the literature generally, before moving to a discussion of the search results below. First, the majority of research on AL is American, which is arguably due to its role as a progenitor for the model. This has implications in terms of generating research that is not always applicable to British Columbia, such as the current focus in American literature on dementia care in AL, ageing in place, or changes to AL funding in the wake of health insurance reforms. Second, searching this literature is very challenging because of the multiple terms used to describe international models of housing for older adults. In addition to search results that referenced long term residential care or nursing homes, other articles referred to ‘retirement communities’, ‘congregate living communities’, ‘continuing care retirement communities’, and ‘extra care housing’ that had to be examined to ascertain whether they were describing something similar to AL or were otherwise applicable. Some studies were more explicit about investigating AL alongside other types of residential care and I chose to include them where relevant. Even the studies set specifically in AL exhibit great variation in research sites – they range from small, room and board type-houses to large, apartment-style residences. Finally, I subscribed to journal alerts from the major journals on ageing, gerontology, occupational therapy and social work throughout my doctorate and also conducted additional

literature reviews at various points in the research and writing process; the body of literature around transition to AL continues to be small. For example, since 2011 I sourced 22 new articles on a range of aspects of life in AL, with only two articles specifically referencing transition or relocation to AL. This may have to do with the trends in American AL literature noted above, or it may signify that academic interest in the project of AL is beginning to wane after several decades.

The following section is organized according to the themes that were reflected in the literature – precipitating and contextual factors of relocation, personal effects of relocation, and influential features of life in AL and long term residential care –offering critique and identification of the gaps remaining.

2.3.2.1 Precipitating and contextual factors of relocation

Although older adults report that they would prefer to remain at home rather than live in AL or residential care settings (Leibing, Guberman & Wiles, 2016; Wagner, Shubair & Michalos, 2010), this is not always possible. As such, a subset of the transition literature discusses the influences and pathways into AL and other types of residential care facilities. The studies comprise a mix of qualitative, quantitative and mixed methods, along with one systematic review (Stone & Reinhardt, 2007).

The literature reflects several common factors related to the context of relocation. Chief among these appears to be a change in health or function as a precipitating factor. Research suggests that episodes of hospitalization or decline in health or functional ability in daily tasks precipitate transitions to higher levels of care, including residential facilities (Cheek et al., 2006; Jungers, 2010; Seargeant, Ekerdt & Chapin, 2010). As well, the probability of moving to receive a higher level of care, such as to long term residential care, increases with age (Peek, Zsembik &

Coward, 1997; Statistics Canada, 2011; Wilmoth, 1998). One Canadian study in this area also indicated the link between a decline in health and transition to AL or long term residential care (Rockwood et al., 2014), with moderate dementia and difficulty carrying out IADLs accounting for the transitions from community to AL. Importantly, the research was conducted in Nova Scotia where AL is solely a private industry, so strict comparison with British Columbia may not be possible. Several studies also point to the combined effects of increased health care needs alongside limitations to personal or professional resources that could otherwise support individuals to remain at home (i.e. ability to modify one's home, ask children for help, or pay for extra services) as influential factors in relocation to long term residential care (Jorgensen et al. 2009; Wagner et al. 2010). Other studies have found that sometimes it is the declining health of the caregiver that precipitates the move of an older adult to a long term care facility (Cheek et al., 2006; Heliker & Scholler-Jaquish, 2006; Kemp, 2008; Rockwood et al., 2014), which speaks to the interconnectedness of transitions.

Second, financial resources appear to be an important factor in where and when an older person moves. In the US, there are relatively few subsidized AL beds for low income individuals (Kemp, 2008; Polivka, 2010; Stone & Reinhardt, 2007). This provides a "structured advantage" for older adults who can afford to pick the timing and location of their move (Burge & Street 2009). In one qualitative American study (Ball, Perkins, Hollingsworth, Whittington & King, 2009), the researchers found that higher socioeconomic class allowed both Black and White older adults to be more proactive, not only in choosing to move before reaching a crisis point or overburdening family members, but also in moving to an AL residence that met their personal preferences. Given that Canada has a more well-developed system of publically subsidized AL,

it raises questions as to whether structured advantage occurs in this country as well. However, I found no Canadian studies that addressed this topic.

Third, research shows that family dynamics and involvement are also part of the contextual and precipitating factors around relocation. For example, some studies have found that older adults opt to move to AL in order to avoid becoming a burden on family members (Cheek et al., 2006; Jungers, 2010), but this can stem either from a proactive, independent decision (Ball et al. 2009) or from a desire to "appease" worried family members (Tracy & DeYoung, 2004). In other cases, older adults spoke of being relocated to long term care facilities against their wishes, particularly after a time of crisis when they could not participate in the decision made by family members (Ball et al., 2009; Young, 1998, Johnson & Bibbo, 2014). Some individuals move to AL to access care for a spouse, rather than themselves (Kemp, 2008; Mulry; 2012). Even in cases where decision-making around moving to AL is made in concert with family members, conflicts can arise over the logistical and emotional aspects of relocation such as the timing of the move, the fit of the available services, or the reality of how the older adult is coping at home (Koening, Lee, Macmillan, Fields & Spano, 2014).

Finally, several studies are unique in their identification of larger structural issues that influence whether or not older adults relocate, particularly the availability of community resources. Young's (1998) grounded theory study of an older adult congregate housing community found that the decision to move was made when the "demands of the former environment exceeded the resources of the individual" and included, among other factors, a lack of public transportation after giving up driving (p. 155). Scheidt and Norris-Baker (1999) made the important observation that the environment itself may change to the point where there is a loss of place attachment or a lack of resources, as in the case of gentrification and other

neighbourhood changes. In the case of small towns, it may be due to the loss or absence of services that support older adults to remain in their homes. One qualitative Australian study found that when available services did not match the needs of the individual in terms of geographic location, hours of operation, or available transportation, individuals were more likely to transition to "residential aged care", in some cases prematurely (Cheek et al., 2006).

It is important that researchers keep developing an understanding of the context around older adults' relocation to AL, especially in light of the limited number of studies investigating AL as a discrete type of housing rather than in combination with other models or levels of care. The multiple influences for relocation reflected in the existing literature suggest: a) that while health is a factor, presence/absence of environmental support and resources are also significant; and b) that it is not always up to the individual to choose when and where they move. The latter point in particular may have implications for how the person adjusts to the event; it also challenges the founding philosophy of AL. Yet there are few studies that explicitly contrast this lack of choice in when/where to move with the popular discourse of AL as a positive, third age destination (see Carder and Hernandez, 2004 as a partial example).

2.3.2.2 Effects of relocation

A second theme in the literature speaks to the effects of relocation to residential care settings for older adults. Often, these studies have employed quantitative measures directed at specific, predetermined outcomes, most often around new residents' health or depression rather than social or emotional aspects of the move for individuals (Tracy & DeYoung, 2004). It does appear that depressive symptoms can be common in individuals recently relocated to long term residential care homes (Achterberg, Pot, Kerskstra & Ribbe, 2006; Scocco, Rapattoni & Fantoni, 2006). There is even a nursing diagnosis which refers to the combined symptoms of "anxiety,

confusion, fear, helplessness, hopelessness, indecisiveness, loneliness, suicidal thoughts and suspicion" among new residents as relocation stress syndrome (Morse, 2000; Walker, Curry & Hogstel, 2007, p. 2). Yet a qualitative investigation by Walker et al. (2007) among both long term care and AL residents questions the usefulness of applying it for two reasons: first, it is not always clear whether these are symptoms of pre-existing and undiagnosed conditions exacerbated by relocation; and second, most participants felt that any difficulty related to their relocation experiences was on par with other life transitions and, as such, was not outside their ability to cope. Critical gerontologists might also point out that a focus on depression and negative symptoms pathologizes older adults for their arguably normal reactions during a time of major transition, or in the face of simultaneous and difficult personal experiences that can precede relocation, such as the loss of a spouse (i.e. Conlon & Aldrege, 2013). Such an interpretation speaks to the dominance of the biomedical discourse in interpreting and treating the 'problems' of older adults. Moreover, a focus on the presence/absence of symptoms does not examine how structural inequalities such as unequal access to health care or home support, the overly medical environment of residential care, or the loss of an older adults' voice in the decision-making process may contribute to feelings of depression.

In an attempt to present a broader picture of the experience of relocation, there have been a small number of studies using qualitative methods. Most of these studies have concentrated on long term residential care homes (for example, Falk, Wijk, Persson & Falk, 2012; Heliker & Scholler-Jaquish, 2006; Johnson & Bibbo, 2014; Lee, Simpson, Froggatt, 2013; Lee, Woo & Mackenzie, 2002a; Sussman & Dupuis, 2014), but there are some that explore the transition of older adults to AL facilities specifically (Dobbs, 2004; Jungers, 2010; Tracy & DeYoung, 2004). What these studies suggest is that the initial psychosocial and emotional responses are similar

between the two settings and that some form of emotional reaction is common in the first few weeks or months regardless of the context of relocation, including feelings of being "overwhelmed, emotional, disorganized…[and] homeless" as a result of the move (Brandburg, 2007, p. 54). Such a reaction is understandable when viewed in terms of the transition frameworks discussed above, in that relocating to both AL and long term residential care represents a rupture between an individual's past and present, which requires some time to adjust. Home, for example, is symbolic of comfort, safety, privacy, independence, possessions, and continuity with the past for older adults (Johnson & Bibbo, 2014; Liebing, Guberman; Wiles, 2016; Sixsmith, 1990). As Chaudhury (2008) points out, our self identities can be deeply bound to physical environments because our memories are anchored to them in an embodied way. As such, the concept of home is built through layers of daily activity, even mundane tasks. "If it is assumed that older people develop and maintain a sense of self through attachment to place, then relocation to a new place is a serious matter" (Eckert, Zimmerman & Morgan, 2001). Not unexpectedly, then, research has found that loss of the physical home is linked to other feelings of loss for both new AL and other long term residential care residents – loss of neighbourhood and friendships, loss of unique identity among so many residents, and unanticipated loss in types of independence such as choosing mealtimes or daily schedules (Heliker & Scholler-Jaquish, 2006; Tracy & DeYoung, 2004). But while they are understandable, these negative responses to relocation are also notable because they contradict the supposed preference of individuals for AL over 'nursing homes' and raise questions around what individuals expect from AL verses what they experience in it. Currently there are no studies examining how the philosophy and discourse of AL inform individuals' relocation and transition.

Yet some older people do manage to find a way to move through the period of disruption after relocation. The literature offers different ideas of what a 'successful' transition entails, but based on qualitative interviews across long term care and AL it appears to involve aspects such as incorporating the move into one's life story (Lee et al., 2013), actively changing one's attitude toward acceptance and positive reframing (Johnson & Bibbo, 2014), feeling a sense of attachment to the new residence (Falk et al., 2012; Heliker & Scholler-Jaquish, 2006), and being able to exercise autonomy (Johnson & Bibbo, 2014; Jungers, 2010).

An important, but underemphasized, aspect of settling in appears to be the element of time, as historically there has been little focus on "the actual experiences involved as older people [make] their day to day adjustment after placement" (Lee, Woo & Mackenzie, 2002b, p.19). A limited number of studies address this gap in the literature, such as Lee et al.'s (2002a) grounded theory study of newly relocated older Hong Kong Chinese adults in long term residential care. The interviews began one week after participants' admission and continued over a series of months. The data highlighted an order of priority for new residents, first of which was learning organizational rules and also ways to acceptably 'bend' them. Only after studying their new environment and the relationships within it could the participants begin to work on integrating their old and new lives. Similarly, Heliker & Scholler-Jaquish (2006) studied transition among newly-admitted long term residential care residents over a period of three months, and found that participants went through an early phase of "learning the ropes" before reorienting and "beginning new stories." These studies begin to hint at the power of organizational structure and policy in shaping the experiences of those moving to AL, raising questions as to how effectively AL has, in fact, integrated some of its foundational values such as choice, autonomy, or independence.

However, while this focus on the temporal aspect of transition adds an additional nuance to our understanding of the phenomenon, it is also important to resist interpretations that transition can be understood according to normalized or linear stages as the above studies (Heliker & Scholler-Jaquish, 2006; Lee et al., 2002a) might suggest. Indeed, research supports the position of the transition frameworks reviewed here in that some individuals struggle after relocation and experience transition as an incomplete or convoluted process with stops and starts in different areas (Meleis et al., 2000; Schlossberg, 1984). For example, one British narrative study (Lee et al. 2013) found that instead of reflecting "time bound" stages of transition, residents' narratives of moving to long term residential care were organized according to turning points or chapters in their personal stories. How settled a person felt was related to larger questions around how to integrate aspects of one's previous life and values in the new setting, and how the move fit with one's identity and expectations as an older person. Some participants could not make peace with the contexts surrounding their transition and, as a result, discursively constructed their residence as a continually unresolved problem. In an ethnographic study of six AL facilities in the United States (Eckert, Carder, Morgan, Frankowski, & Roth 2009) found that the process of feeling settled in could happen very quickly for some and take up to a year for others, especially in light of episodes of hospitalization and rehabilitation. These two studies point to the importance of exploring extended personal accounts that include biographical details, in order to capture the complexities of relocation that do not align with stage-based models.

Other researchers have also noticed the lack of extended accounts of transition. In particular, the motivation for one Canadian study on transition to long term residential care was directly linked to the paucity of research on the entire process of transition, "including residents'

experiences with the actual move" (Sussman & Dupuis, 2014, p. 440). The grounded-theory study included a temporal exploration of relocation, as participants reflected on their experiences pre-move, during move-in, and in the initial days. As well, the study is unique for drawing explicit attention to the multiple layers of influences that were referenced in positive and negative stories of relocation. Specifically, conditions at "individual, interpersonal and/or systemic layers" that "nurtured a sense of control and a sense of respect for personhood" (p.451) contributed to a sense of comfort and belonging in the new residence. More studies that follow participants over time or 'talk through' participants' relocation steps, especially in AL, could generate nuanced descriptions of the ways that older adults shift (or do not shift) their expectations, interpretations, or identities, over time as a result of the move. In addition, this approach could provide greater insight around the points during relocation where policies, discourses or other structural influences interact with individual transition experiences, since reaction to the institutional context appears to be a significant aspect of relocation. For example, Sussman and Dupuis highlighted how the requirement for participants to accept a placement in a very short period of time made it very difficult for them to process any of the transition before moving day was upon them. How this and other policies and practices affiliated with AL shape the transition process is currently unknown.

A final gap in this literature speaks to Grenier's (2012) concept of finding continuity within transition. This idea is alluded to in many studies, but not often directly explored as being a part of adjusting after relocation. For example, studies may highlight demographic characteristics or previous occupations as part of the participant descriptions, but do not typically incorporate these biographical details in the analysis of how different participants settle in. Although not a study of relocation itself, Yamasaki and Sharf's (2011) narrative study of older

people in AL illustrates how residents made linkages between their past and present experiences as a way of interpreting life in a congregate environment where they would prefer not to be. Combining this approach with a more sustained exploration of the process of transition to AL over time could be a useful way of extending our understanding of how older adults interpret and adjust to relocation to AL, including how it is the same or different from transitioning into to other types of residential facilities that do not explicitly claim the values associated with AL.

2.3.2.3 Influential features of life in AL

A more substantial body of literature exists in relation to specific aspects of life in AL and long term residential care, such as relationships, activities, environmental aspects, and structural considerations. Often these domains are approached in relation to, or nested within a larger investigation on satisfaction and quality of life (QOL) for older adults living in formal care environments (see for example Ball et al., 2000; Eckert et al., 2001; Kane, 2001; Mitchell & Kemp; 2000). The themes emerging out of that research demonstrate the importance of considering how characteristics of the physical, organizational, and social/affective environment interact with personal characteristics such as social location and personality to influence feelings of satisfaction after moving to AL (Ball et al. 2000; Cutchin, Owen & Chang 2003; Falk et al., 2012; Mitchell & Kemp 2000, Sikorska 1999). Qualitative research is well represented in this literature, which demonstrates an important incorporation of older adults' own perspectives in furthering gerontological knowledge. What is often lacking in the studies set in AL, however, is an explicit link between the features of life identified as having positive or negative influence for residents and how they reflect/do not reflect the purported values or benefits of AL such as choice, autonomy, independence, or social connection. In this section I will consider some of the

most common findings about positive/negative features of life in AL in light of the model's core philosophy and values.

Privacy, for example, appears to be one of the values that is well supported in AL. Several studies have indicated that one of the most positive aspects of AL appears to be the prevalence of private suites furnished with at least some personal belongings, which helps to maintain a sense of continuity and identity between residents and their former lives (Ball et al. 2000; Eales, Keating & Damsma, 2001). Moreover, research suggests that private rooms provide an important avenue of control for residents in helping to mitigate some of the territoriality that can occur in congregate living settings (Cutchin, 2003). Other studies have linked private rooms with enhancing social connections in terms of allowing privacy to make phone conversations (Ball et al. 2000) or providing intimate space for residents to socialize (Dupuis-Blanchard, Neufeld & Strang, 2009). Regardless of facility type, private rooms appear to be a beneficial amenity – in a study comparing independent living, AL and residential care homes, having a private room or not having to share with unrelated roommates were linked to lower rates of resident depression (Robinson et al., 2011).

Social connection has also been considered a benefit of living in AL, but the literature presents a more varied picture of the success of the AL environment in providing it. There tends to be three types of relational foci in the literature – peer relationships, relationships with staff, and external relationships. In terms of peer relationships, research indicates that, while new social bonds among peers are formed inside AL and other seniors housing/long term care settings, they are not necessarily close friendships (Cutchin, 2003; Dupuis-Blanchard et al., 2009). As well, issues of interpersonal difference can further inhibit resident relationships and connections, given that congregate living settings force a level of interaction between people

who might not otherwise associate (Yamasaki & Sharf, 2011). For example, some studies show evidence for discriminatory behaviour or language between residents based on physical frailty and cognitive impairment (Cutchin, 2003; Hubbard, Tester & Downs, 2003; Jaffe & Wellin, 2008). Another study found that women can feel unsafe in a mixed gender environment, particularly among male residents who make sexual advances (Cutchin 2003), while other research demonstrates that gay, lesbian, bisexual or transgendered residents can face open or underlying discrimination in residential care (Donaldson, Asta, Vacha-Haase, 2014; Walker et al., 2007). Two Canadian studies also suggest that the ethnocultural composition of the facility influences the social experiences of ethnic minority older adults who relocate to long term residential care or AL (Baumbusch, 2008; Koehn, Mahmood & Stott-Eveneshen, 2016), in the sense that residents may face isolation in the absence of others who share the same language or cultural worldview. From a critical perspective, these studies illustrate how dominant discourses and power structures from wider society can be replicated within AL, and how these might influence the subjective transition experience.

Literature on resident relationships with staff in AL indicates many care workers report a high level of commitment to residents and have positive relationships with them (Kemp et al. 2009; Kemp et al., 2010). Positive relationships with staff have also shown to be salient in helping AL residents come to terms with relocation (Ball et al., 2000; Jungers, 2010; Street et al., 2007). Further, a “cohesive environment” that fosters close relationships between staff, residents, and families was rated by participants in one study as contributing more to QOL than organizational features of the facility like schedules and policies (Mitchell & Kemp, 2000)., Yet, aspects of difference can negatively influence resident-staff relationships, particularly racism of white residents towards immigrant or ethnic minority staff (Kemp, Ball, Perkins, Hollingsworth

& Lepore, 2009; Kemp, Ball, Hollingsworth & Lepore, 2010), which is important when considering the context of British Columbia where many residential care workers are from visible minority groups.

A third relational focus in the literature is the influence of external relationships on residents' satisfaction in AL. Findings indicate that this is a complex phenomenon. One study showed that while continued ties with family, particularly with children, appear to be very important to quality of life, participants also described being dissatisfied with the amount of contact they had with family members (Ball et al. 2000). Similarly, other research indicates that low frequency or duration of visits can be a source of dissatisfaction for newly relocated residents, in the sense that they may look to old relationships to maintain a sense of continuity in the face of change but find themselves "wanting more" than others give (Tompkins, Ihara, Cusick & Park, 2011). In fact, Burge & Street (2012) found that continued relationships with old friends did not improve perceptions of QOL after relocation; the authors suggest that these relationships may be "reminders of the loss of independence or nostalgia for an earlier social milieu, or the temporal frame may invoke comparison with healthier, community-dwelling elders" (p. 15). Yet, other studies suggests that external connections are valuable in cases where they act as a buffer to difficult relationships with staff, especially for those with lower income and less choice in facility (Burge & Street, 2010). Researchers have also begun to examine the role and frequency of residents' access to the external community and how this influences adjustment to AL (Ball et al. 2000; Cutchin, 2003; Cutchin et al., 2003; Cutchin et al., 2005). This is important, because although AL residents are conceptualized as having more independence than older adults in long term residential care, there is some evidence that moving to AL is actually associated with a reduction in involvement in community activities (Cutchin et

al., 2005). Maintaining place attachment to community could provide a sense of continuity and identity for residents; in small towns this may partly be realized through prior community relationships between care staff and residents (Kemp et al., 2009). Taken together, the research on peer-to-peer, resident-to-staff and external relationships suggests that simply moving to an AL residence does not, in itself, foster social engagement. Research that identifies what residents themselves would like to see in terms of opportunities for social connection is therefore important, but not found in the literature.

Other research on the influential features of life in AL also hints at an implicit recognition of the tension between the founding philosophies of AL (such as choice, independence, and individuality) and the organizational practices of AL facilities. For example, although making the choice to move to AL or being actively involved in process is generally equated with higher satisfaction after transition (Burge & Street, 2010; Street & Burge, 2012), research demonstrates that AL facilities do not necessarily offer *continued* opportunities for choice within AL to support residents' highly valued sense of independence and autonomy (Ball et al. 2000; Jungers, 2010; Koehn et al., 2014; Mitchell & Kemp, 2000; Sikorska 1999). This is notable, because although AL is often contrasted with long term residential care homes as being a more self-directed environment, one study on transition to AL found that "the loss of independence was one of the most prominent risk factors related to relocation"; experiences such as giving up a car or lack of control over one's daily routine fostered a sense of "uselessness" or "incompetence" (Jungers, 2010, p. 419-420). Research also highlights several ways that facility regulations restrict choices at individual and structural levels. For example, AL residents speak of prohibitions on over-the-counter medications in their rooms and not being able to control maximum water temperature (Dobbs et al., 2008); having rigid meal schedules and menus (Ball

et al. 2000; Dobbs, 2004); facing both unofficial and official restrictions on visitors (Bennett et al. 2017); and limited opportunity to effect changes in policies or practices (Mitchell & Kemp, 2000). Activities organized by the facility can foster a sense of choice, but research indicates that simply offering more choices does not increase resident satisfaction (Sikorska, 1999).

As observed by Cutchin et al. (2005), the key appears to be offering "purposeful activity", where "the purposes may vary by person, but the majority of activities do not appear to be about filling time or simply keeping busy" (p. 18). In contrast, some facilities offer "programming and other amenities based on a stereotype of generational preferences rather than individual preferences" (Dobbs et al. 2008, p. 523), which contributes to a sense of discontent or even infantilism (Dobbs et al. 2008; Jungers, 2010; Mulry, 2012). In other cases, organizational support for residents to facilitate their own activities is lacking; one Canadian study described how a participant's repeated letters to the management of her AL facility, wherein she volunteered to beautify the neglected garden, were met with silence (Egan, Dubouloz, Leonard, Paquet, Carter, 2014). In general, what appears to make choices meaningful for residents is related to "a person's values developed over a lifetime", and inhibiting these choices can exacerbate feelings of depression or loneliness (Ball et al., 2000, p.320- 321).

Outside of day-to-day choice, other research highlights areas where the philosophy of AL contrasts with larger structural practices and priorities. As mentioned, 'ageing in place' is another philosophical tenet of AL in the US. In actuality, facilities make the final decisions on allowing residents to stay, and the varying models of AL mean that ageing in place may be possible in some facilities but not others. In the more restricted AL facilities, some residents to try to 'pass' as less dependent or continually negotiate exceptions in order to remain in AL (Cutchin 2003; Dobbs et al. 2008). Others feel the strain of living somewhere for an

“undetermined” period of time until their care levels change, something Frank (2001, p. 11) has termed “prolonged residence” in contrast to true ageing in place. In Canada, AL is not structured for ageing in place so residents may not have that expectation. Residents might therefore face similar difficulty settling in, knowing that a change in their health could force a relocation to long term residential care at any time. However, there appears to be a gap in the literature around this topic. As well, researchers have articulated the tension between the right to live with a degree of managed risk, as espoused in the AL philosophy, and facility emphasis on safety and liability (Carder & Hernandez, 2004; Kane, 2001; Mollica, 2008). Again, Canadian literature is in this area is limited (see Koehn et al., 2016 as a partial exploration of this). Studies that investigate the interplay of discourse and practice in Canadian AL are important because AL is becoming an important part of the spectrum of care for older adults across the country, but it has not yet faced the same degree of critical investigation and debate as has long term residential care. More research that includes a direct focus on the discursive construction of AL could illuminate areas of disjuncture between promise and practice.

2.4 Chapter summary and statement of research purpose

The three conceptual components I have discussed in this chapter have helped me ‘find my way into’ my research topic. First, my ontological positioning of critical theory and social constructionism encouraged me to question the way that ageing and housing in late life are currently conceptualized and structured. With these paradigms, I was able to approach the concept of AL as something constructed through discourse, policy, and the actions of real employees and residents.

Second, a focus on the dominant and alternative discourses of ageing helped to draw out the ageism inherent in a Western response to growing old, including our system of care for older

adults. A preoccupation with biomedical treatments, individualistic responsibility for successful ageing, and the social and economic dependence of older adults has meshed with neoliberal values to perpetuate a negative, role-less, and marginalized position for older adults. This is then reflected in our system of care, where older adults are housed in age-segregated environments away from community life. Alternative discourses, on the other hand, refocus our attention on the interdependent, embodied experiences of individuals and recognize the ways that older adults from multiple social locations navigate and resist negative stereotypes.

Third, an immersion in the theories of transition and the research on relocation to, and life in, AL provided me with information on what is known about this phenomenon and what aspects still require further development. Much of the research reviewed here appears to implicitly support the theories of transition that point to the influence of personal, temporal, environmental, and structural factors in how a person adjusts, including the possibility that some older adults might never completely settle into AL facility. Qualitative studies in AL and long term residential care have begun to build a common understanding of what early experiences of transition are like and how older adults describe their sense of being settled, but there are still some gaps, especially in terms of studies investigating AL as a discrete type of residential care. Further, it is important that Canadian knowledge be developed in order to draw out aspects of relocation and transition that reflect unique system structures, funding models, entry points, and service philosophies. In addition, more sustained, temporal descriptions experiences of moving and settling in would be useful in building a more nuanced understanding of transition over time.

On another level, the literature reviewed here speaks to the tensions between the founding philosophies of AL and the way that these are carried out in practice. The importance of private rooms and spaces, the ability and freedom to associate as one would prefer; the options available

for dining, recreation and care – these are related to core AL values of choice, independence, and autonomy. Yet there is a lack of literature that specifically examines residents' perspectives of relocation alongside the unique philosophy and discourse of AL to explore how it has informed their experiences. Where studies that do touch on the subject, it is often difficult to interpret the results in a British Columbian context, given the multiple ways AL is operationalized.

It is necessary for researchers to continue to challenge and refine the philosophy and practice of AL. If it is simply perpetuating the regimented practices of long term residential care in a different guise, it is not fulfilling its intended purpose. Qualitative accounts of embodied, temporal, and spatial experiences in AL facilities can provide additional data with which to review the project of AL. Soliciting the experiences of people living in this environment is key, because their position as service-users gives them unique insight into how AL policies are carried out from day to day.

The purpose of my research was therefore to explore older adults' narratives of moving to AL, paying attention to the structural, discursive, and contextual elements of their stories. I was interested in hearing detailed accounts of what it is like to move to AL, and how older adults' life courses might be reflected in the ways they talk about, experience, and perceive their relocation. As well, I wanted to know whether dominant discourses, such as that of ageing or AL, were employed in telling these stories and whether older adults used alternate discourses to describe their transition. My research questions were:

1) What are older adults' experiences of moving to AL?
2) How do older adults speak about AL in these accounts?
3) How do older adults speak about ageing in these accounts?

Chapter 3: Research Design and Methodology

My interest in the detailed accounts of older adults' relocation to AL, as well as my positioning within the social constructionist paradigm, fit well with using a qualitative, critical, narrative approach for this study. I begin this chapter by briefly highlighting the key features of each approach before outlining my research design, execution, and stages of analysis. I will then discuss issues of credibility, validity and limitations. The last section of the chapter introduces the participants and provides a brief description of their AL facilities.

3.1 Qualitative, critical and narrative methods

The lens of qualitative research is attuned to "how the social world is interpreted, understood, experienced, produced or constituted" (Mason, 2002, p. 3).While the specifics of research design can shift according to where a researcher positions herself or himself across the qualitative spectrum, there is an understanding that some research questions are best explored using its flexible, inductive and description-based methods. The emphasis on in-depth interviewing to elicit rich, contextual accounts of people's experiences distinguishes qualitative research as a suitable approach in exploratory research as well as in research that seeks to understand complex social phenomena (Singleton & Straights, 2010).

In a complementary way, critical qualitative research directs the researcher to inquire "not only about what is constructed, but… *how* it is constructed" (Patton, 2002, p. 102, emphasis added). To this end, discourses, power dynamics and structural influences are included in the researcher's data and analysis. As well, critical inquiry involves being self-aware as a researcher and recognizing the role of ideology and values in what we consider to be "facts" about a phenomenon (Kincheloe & McLaren, 2005). Drawing on the historical focus of critical theory as

discussed in Chapter 2, there is also a fundamental idea in critical research that social inquiry should include an element of "emancipatory interest" (McCarthy, 1978, p. 76). The term "critical" has therefore been applied as an umbrella term for, or a stance within, research that generally aims to expose hidden power and assumptions and that seeks to redress current social or political inequities.

Finally, narrative inquiry is essentially research that centres on stories and their study (Wells, 2011). It stems from the assertion that we use stories to organize our experiences, to represent ourselves to the world, and to interpret the social world around ourselves (Baldwin, 2008; Bruner, 1991; Gubrium & Holstein, 2009; Plummer, 1995; Sarbin, 1986). Storytelling appears to be an innate human activity; it appears very early in childhood and "happenings in our own lives are eventually converted into more or less coherent autobiographies centred around a Self acting more or less purposefully in a social world" (Bruner, 1991, p. 18). There is also evidence to suggest that, even in cases of cognitive impairment where certain verbal aspects of storytelling are restricted, individuals are still motivated to perform stories in a relational and embodied way (Hydén, 2013a; 2013b). Since people are agents in a socially constructed world, the stories we tell about ourselves and others incorporate and reflect the influences of social location, discourse, power, and resistance at play in wider society. For this reason, narrative inquiry is particularly suited to my research questions because it "honors people's stories as data that can stand on their own as pure description of experience…or analyzed for connections between the psychological, sociological, cultural, political, and dramatic dimensions of human experience" (Patton, 2002, pp.115-116). I was also attracted to narrative inquiry because of its ability to keep participants' stories intact and contextualized. While comparing the themes of

different narratives can occur as one part of the analysis, individual narratives can also be explored as discrete units (Reissman, 1993; Wells, 2011).

Further, narrative methods are well established in several areas related to this study: social work, gerontology, and health care. Gathering narratives of clients' experiences is a cornerstone of social work practice, and case studies are commonly used for didactic purposes with students and teams. Narrative therapy is also used to reframe client experiences and help them move forward. However, there appears to be less narrative research *published* in social work than in other traditions (Riessman & Quinney, 2005), which is something I hope this study can help address.

In health care literature, use of personal narrative and life review has been promoted as a way of improving life in residential care for older adults. Studies have explored how narrative can be used to help residents find continuity of meaning in their lives despite living in institutional settings, and also how it can facilitate more responsive care based on that which residents identify as meaningful (Heliker, 1997; Moore, Metcalf & Schow, 2006). These types of investigations are valuable because older people's experiences and "interpretations of what it means to age, may illuminate some aspects of human life that are more important than the items that currently fill the social agenda" (Baars, 1997, p. 261). In this vein, the work of Gubrium (1975, 1993) and Gubrium and Holstein (1999) uses narrative and ethnographic data collected in residential facilities to draw connections between the experiences and insights of residents and dominant discourses, practices of power and resistance, embodiment, and constructions of identity and meaning. In more general health care research, gathering service-user narratives helped the National Health Service in Britain to solicit aspects of care that were the most salient for patients, rather than relying on satisfaction surveys that limited the types of response received

(Wilcock, Brown, Bateson, Carver & Machin, 2003). Aside from identifying themes or details that even the participants may not have realized were significant, the method redresses the power imbalance of the traditional method of interviewing by allowing the participant to direct their own account. Similarly, the work of Surr (2006) demonstrates how unstructured interviews can be used in conjunction with techniques of interpretive biography to create rich understanding of the lives of persons with dementia.

Narrative research has also been used in studies that explore the significance and experiences of ageing. One Finnish study (Vasara, 2015) examined older adults' narratives about moving to different types of assisted housing; their stories demonstrated how individuals reinterpreted the dominant cultural narrative of ageing in place to find meaning in the relocation. Kaufman's seminal work *The Ageless Self* (1989) used the life stories of older adults to contribute to new theoretical perspectives on how older adults "perceive meaning in being themselves in old age" (p.6). Indeed, the research of Nilsson et al. (2000) indicates qualitative and narrative research may fill a need for older adults; during the data collection on experiences of feeling old, participants sought information from the researchers on what the other participants had said about their experiences and whether their own experiences could be considered normal. Narrative inquiry is therefore amenable to the emancipatory coals of critical research because it opens up the space for older adults themselves to shape the available discourses of age.

3.2 Data generation

3.2.1 Participant recruitment

I began learning, both about AL and about the research process, from the beginning of my study. My original participation criteria were: individuals who were either scheduled to move

into AL imminently, or who had moved in within the last six months, and who were comfortable interviewing in English. My goal was three to five participants who would be interviewed up to four times each. Although I eventually did find four participants, the route to finding them was circuitous.

I had intended to set my research at one or two chosen AL residences in the Vancouver Coastal Health Authority, to allow for better contextual understanding of what participants' might reference about living there and to see if there were differences of experience within the same environment. I approached two potential residences; both were publically subsidized AL facilities in the Vancouver Coastal Health Authority. I chose publicly subsidized residences as I felt this would best reflect the experience of people with a range of income levels and because of the Canadian tendency toward public health care.

One site was willing in principle, but they felt that asking people to participate as soon as they moved in was problematic. In their experience, many people were too frail upon moving in to participate (residents typically were in their nineties) and they preferred that I wait until after six months to conduct interviews. As well, they felt that providing recruitment material at the same time as moving in would be interpreted by individuals as *having* to participate as a condition of being accepted as a resident. Based on their observation around health at the time of moving in, I decided to extend my period of eligibility to those who had moved within 12 months. However, I did not want to categorically agree that I would wait until six months had passed before approaching residents. I wanted to capture as much of the transition as possible, so if a person felt able before then I wanted to be able to interview them. I therefore decided this AL site would not be a good fit. At the same time, the other site I had approached mentioned that although they were willing, they doubted I would be able to find enough participants there

because the waitlist was so long and no one was scheduled to move in. The residents who had been there less than six months were not fluent in English and were experiencing health troubles, so the administrator did not feel that they would be interested.

Already I had learned about the slow turnover for AL units, as well as a higher age bracket and lower quality of health than I was expecting. I also realized that it was not likely that I would be able to interview people who were about to move into AL, because the length of the waitlists meant that individuals would not know when they would get a placement and their move might therefore not fit within my data collection timeline. If their health was compromised, as the AL sites suggested it might be, they would be even more unlikely to want to participate amid the stress of moving. For these reasons, I decided to recruit in successively wider ways.

My first step was to contact two seniors' centres in the vicinity of AL residences and ask to put up recruitment posters (Appendix A). My thought was that, since AL residents are considered independent, they may continue to go out in their neighbourhoods for socializing and programming. I also obtained approval to recruit through a private AL site with several publically subsidized units and that had welcomed research projects in the past. These steps also proved ineffective – although my flyers at the seniors' centres were reportedly all taken, I received only two calls via one of seniors' centres and the individuals were not suitable to participate. At this point, I expanded my recruitment to incorporate all eight publically subsidized AL facilities in the Vancouver Coastal Health Authority, and I gained ethics board approval to include word of mouth recruitment as well.

At this point I would like to comment on the issue of participant confidentiality as it relates to older adults and their status as a "vulnerable population" in research ethics. The method of approaching residents that was approved by the Health Authority was for me to

provide a research poster to the Manager of AL, who then sent a letter of introduction and my poster to the administrative staff at each of the ALs. There appeared to be a concern that if I were to hold my own information sessions about my project within the ALs, residents might feel pressured to participate or they might recognize one another and feel that somehow their anonymity (if they eventually did decide to participate) would be compromised. It is true that the AL environment is intimate, much like a small town, and people can feel restricted or judged. My belief, however, is that residents are wise about their own needs, so they could decide to participate in an information meeting or the wider study as they wished. Also, AL residents are meant to be independent and their suites are treated as being rented, yet there was a level of protectionism and gatekeeping at play. If I had the chance to explain my study in person, to demonstrate my genuine respect and to answer any questions, perhaps it would have resulted in more participants. As it turned out, I was reliant on various administrators to both comprehend my larger purpose and to 'sell' my project to their residents.

Several of the AL facility mangers were supportive and approached the residents they felt were suitable. In particular, one AL residence with a history of welcoming researchers taped my posters to the door of every AL resident and, from what my one participant told me, made it plain that residents were entitled to speak their minds with no consequence from the residence. From this site, which I will call Forest Place, I obtained two participants. From word of mouth recruitment, I obtained another two participants, for a total of four. I will provide a brief description of them and their AL residences later in this chapter.

3.2.2 Documents

During the time that I was recruiting participants, I was also collecting publically available documents related to AL in British Columbia. The purpose of this was to provide a

contextual background that would help me develop interview questions and also clarify what AL looks like in this particular locale, given that the legislation and structure of AL vary so widely. Finally, I wanted to use the documents to create a discursive 'story' of AL; a backdrop of regulation and conceptualization against which the participant narratives could be explored. I collected a number of documents, including seniors' care and housing marketing material, government legislation and publications, Health Authority publications, and handbooks from publicly subsidized AL sites. I present the summary and analysis of documents in Chapter 4.

3.2.3 Participant interviews

Participants were interviewed in a location of their choosing at least one time to record their relocation narratives, and up to four times for clarification and elaboration. Each interview was recorded using a digital audio recorder. I had planned to allow each potential participant time to reflect on their interest in participating between explaining the study and the signing of consent forms, but all participants declined this step and agreed to participate immediately. Therefore, all first interviews were preceded by a discussion around the purpose of the study, my ethical obligations as a researcher, the right to anonymity and withdrawal from the study, and finally, the signing of the consent form (Appendix B). I began each interview by asking participants to tell me the story of how they came to live in AL, beginning wherever they chose. I had several prompt questions prepared in case certain information was not covered (see Appendix C). One participant, located in a small town in the Fraser Valley, was only available for a single interview and declined further involvement because she felt she had said all she needed to say. I had spent the entire morning with her in her AL residence and had lunch with her in the dining room, however, so I did have contextual data as well. A second participant was interviewed one time in person, in her suite, for an hour. She also walked me through the

common areas of her AL residence afterward. A second interview was conducted two months later over the telephone for approximately half an hour, as she lived in a small city in the interior of the province. The third participant, who lived in Forest Place in Vancouver, gave an almost four hour account of her relocation narrative, as well as three follow up interviews that ranged from an hour to two hours. The interviews took just under a year to conduct, with the spacing as follows: two months between the first and second, two months between the second and third, and six months between the third and fourth. This participant always preferred to meet in a coffee shop, but we spent time talking about the physical environment of her AL residence. The fourth participant also lived at Forest Place, and we conducted all the interviews in his suite so I was able to observe the site myself. During our fourth and final interview we went on a walk-through of the common areas. His initial relocation interview took place over an hour and a half; subsequent interviews ranged from just over an hour to just under two hours. His first three interviews were spaced approximately one month apart; the fourth one was just 20 days after the third. When I tried to schedule a fifth interview, I found, sadly, that he had passed away.

All participants were mailed a copy of the transcript from their first relocation narrative interview and given a chance to review it before the second interview. My purpose in sharing the interviews was partly to perform member checks, but also allow the participants the opportunity to remove any information they did not wish to be shared. As well, since these were the participants' own reflections and recollections, including biographical anecdotes, I felt they might wish to have a copy of their stories to keep. This approach reflects the position of critical qualitative researchers that attempts should be made to recognize and rebalance the power differential that can happen in the researcher-participant relationship (Karnieli-Miller, Strier & Pessach, 2009). It also stems from the epistemological position that there is no 'pure' or 'true'

version of a story, since we perform them based on the context and of their telling and the purpose we believe them to serve. Similar to comments made by Plummer (2001) or Riessman (1993), the goal of a second interview or other member checks was not to pin down the exact truth of the original relocation narrative, but to expand and deepen the account. If a participant wished to reformulate, remove, or even contradict a section, it would be their prerogative because it would support their identity as they wished it to be represented. As it turned out, no one had any objections to, or specific comments on, what was written, other than some jokes about how the conversational "ums" made them sound less articulate.

The reason for including walk-throughs as part of the interview process was inspired by the work of Phoenix and Sparkes (2009), who found that they could elicit different types of information from their participant in different settings. In the formal interview, they obtained 'big' stories featuring biographical narrative content centred on the specific topic of the research. When simply spending time with the participant, they were able to hear spontaneous 'small' stories that provided a glimpse into his inner world. In my project, I did not approach the walk-through as would an ethnographer; spending long periods of time observing the setting and individuals in it. Although I observed the features and atmosphere of the spaces as much as possible, I followed the pacing of the participants and was generally focused on their reactions and comments. I had a few prompt questions prepared (Appendix C) but used them varyingly because the context of each of the three tours was very different. I will provide some of this environmental data later in the chapter as I introduce each AL residence and participant.

3.2.4 Field notes and research memos

A third type of data generated in the study was from field notes and research memos. After each interview, I wrote a series of impressions, contextual information or ideas to pursue in

the next interview. I transcribed all of the first interviews myself and several of the follow up interviews, during which time I often stopped to write down additional memos about hunches or clarifications needed. For the interviews that were transcribed by others, I listened to the recordings while reading the transcripts in order to ensure accuracy and to check that the meaning I felt was conveyed by the participant or myself was reflected in punctuation or directive notes around intonation or body language. Again, I often stopped to record memos while undertaking this process. These memos were important in helping to generate questions for subsequent interviews and were also a way of building trustworthiness into the data generation. In particular, I followed a series of reflexive questions that Wells (201, p. 121) suggests the researcher employ as a matter of course during the research process that relate to issues such as: the researcher's attitude towards the participant, the effects of emotional responses on the recording and analysis of data, location of power during the research process, how theoretical assumptions or methodologies might have affected data collection, analysis and interpretation; and considering what alternative explanations or interpretations are possible from the data collected.

3.3 Data analysis

Data analysis in this project was a multi-step, iterative process. The documents and transcripts were first analyzed separately. As mentioned, the document selection and analysis will be discussed in the following chapter. Early analysis of the interviews began with memos and field notes as described above; I used the gaps in my knowledge and my hunches to create questions for the follow up interviews. For the formal analysis of interview transcripts I used the qualitative software program Atlas.ti, which was helpful in allowing me to tag passages with

multiple codes and to create memos around entire sections. I analyzed each participant transcript in three ways. The first was a thematic content analysis, where I read for recurring themes and topics. These eventually developed into a list of codes that applied across all interviews. Some of these codes were related to aspects of the move to AL, such as how the decision was made to look for an AL residence, how that particular site was chosen, how family members were involved, how long the person was on the waitlist, and details of the moving day. Other codes related to organizational aspects of AL, such as policies, programs, services, and staff. The physical and social environment was another code family. I also made note of spontaneous sub-narratives embedded into the larger relocation narrative or interview. As well, I created codes around existential topics such as ageing, independence, comparing abilities, and values. My goal in creating these different types of codes was to tease out the 'factiticites' of the narratives – the personal, interpersonal, sociocultural and structural aspects of lived events (Denzin, 1989; Kenyon & Randall, 1999) – as well as to think about a "three-dimensional narrative inquiry space" comprised of the "personal and social (interaction); past, present and future (continuity); [and] the notion of place (situation)" (Clandinin & Connelly, 2000, p. 50).

In the second reading, I paid attention to the different voices in the narratives. In particular, I was looking for examples of where participants' voices were active or passive, how they described their thought processes or internal dialogues, and how they represented others in the quotes or anecdotes they used. I was interested in hearing the shifts of power in the narratives and the discursive references to AL or aspects of ageing. Here, I drew on Bakhtin's concepts of heteroglossia and polyphony (Vice, 1997, p. 113). Heteroglossia is similar to the idea of discourse and refers to different languages present in a society – professional, class, colloquial, formal, women's, men's, etc. Polyphony describes the difference voices of different characters,

but Bakhtin also used it to describe cases of characters' self reflection and internal voices. By examining voices, I hoped to orient myself to how participants linked various discourses into their personal narratives and interpretations of experience.

In the third reading, I made memos around points of the participant narratives that resonated with me. I included this step partly to incorporate reflexivity in my research, a component of qualitative trustworthiness (Wells, 2011), and partly to expand the analysis on another level. Being aware of my own assumptions and responses was important in order to keep focused on what participants were saying about themselves and their own lives, instead of analyzing based on my own experiences. It was also a good way to keep track of how my response to any particular comments may have influenced the course of the interview. This was a different process than the field notes and transcription memos, because by the third reading I had a deeper engagement with the transcripts. It gave me a space to reflect in a ‘messy’ way, and then incorporate those observations relevant to the larger analysis with a more distanced and critical eye.

During the analysis of the data from individual participants, I began to see several cross-case themes emerge. However, I felt reluctant to fracture or constrict the narratives to in order to present theme-related discussions. The power of the narratives seemed to be in their ability to portray the vitality and personality of the older adults and the contextuality of their transitions to AL. I was also having difficulty recruiting a fifth participant. As I was still in the process of data collection, I decided to expand the number of interviews with the two Forest Place residents and draw on techniques from interpretive biographical analysis to build their cases. In particular, I incorporated interview questions and analysis around the participants’ reflections on relocation and on other transitions in their lives (Denzin, 1989).

In choosing my cases I used a combination of convenience and purposeful sampling. Pragmatically, the Forest Place participants were local, and one of my other participants had already expressed her feeling of being done with the study. I was fortunate, however, that the Forest Place participants demonstrated good variation in their cases: they represented both male and female social locations, they came from different economic classes, they had very different paths of entry to AL, their narrative styles were quite different, and they had experienced different levels of success in settling in after relocating. Because of this variation, I felt confident that they would be interesting and illuminating cases. I also thought this approach would be consistent with accepted narrative conventions for exploratory studies. Narrative researchers have argued that, when consistent with the study goals and when interviewing and analysis is undertaken in depth, a small number of cases – at times even one – may be sufficient (Baker & Edwards, 2012). In addition to the thematic content analysis of the AL documents and the four sets of transcripts, and the discursive analyses that I discuss below, I felt that the inclusion of two in-depth case analyses would present an engaging way of illustrating key themes, contextual details, and temporal aspects.

To develop the case studies for Rose and Ian, I analyzed all four of their interviews for narrative elements and personal themes. I constructed abbreviated accounts of their relocation narratives using illustrative quotations punctuated with my own analysis and linkages to the aspects such as the context of telling the narrative, the context of the relocation in Rose and Ian's lives, pertinent biographical details, important relationships, and personal values and identities. The aspect I found most challenging in doing so was how to present the data in a way that met the constraints of written accounts, despite the fact that the original narratives had taken hours to collect, were often out of sequence, and had been iteratively developed over the course of several

interviews. Yet the process of collating the data around common themes and turning points proved very useful, because I was able to see contradictions, nuances of meaning, and larger implications of key topics across the interviews.

In partial response to these challenges, I decided to use poetic transcription to create poems that prefaced each chapter, in order to introduce Rose and Ian in their own words. Poetry is an effective vehicle to present long narratives, because it is able to compress accounts while retaining the emotions and context (Furman, 2006). To create the poems, I followed the rules developed by Glesne (1997): the words must be participant's; the phrases could be from anywhere in the transcript; the phrases must honour the participant's way of speaking; and I had permission to slightly change words for coherence and depict the essence of the theme. Although poetic transcription is more a technique of representation than analysis, I found that in pulling the most evocative and resonant passages from the transcript I was also reinforcing the themes I had identified in the content analysis and memoing process. A further benefit was that poetry invites empathetic positioning that is different than reading quotes surrounded by academic analysis. It allows the reader to think " ...*with* rather than *about* the participant's experience. In the context of older persons, often words are spoken *for* them or *on* them, but here using poetic inquiry, [one is] able to speak *with* them" (Miller, Donoghue & Holland-Batt, 2015, p. 416, original emphasis). The relocation poems therefore allowed Rose and Ian a direct platform for interaction with the readers of this dissertation.

After completing the cases and the cross-case content analysis, I moved to a third level of analysis focused on the ways that discourses and discursive social structures were represented and used within the participant narratives. In particular, I was interested in how participants spoke about ageing and moving to/living in AL, and the ways that their discourses supported or

challenged the discourses from the AL literature and the dominant discourses of ageing. Taken together, the three types of analysis conducted on the data in this study – individual document and transcript analysis, cross case analysis, and discursive analysis – provided a multifaceted view of the process of moving to AL.

3.4 Validity and credibility

I have addressed aspects of validity, and credibility in previous sections, but I reiterate them here. In addition to the incorporation of reflexive activities into the research design and analysis, member checks, and supervisory/committee feedback during the process of data collection and analysis, I turned to literature on qualitative and narrative research methods for guidance. A key point from this literature is that how one measures the validity in a study is related to one's epistemological position. Social constructionist and narrative researchers tend to be interested in subjective meaning-making over verification of 'facts' in participant accounts, because facts themselves are the products of interpretation, and our interpretations are influenced by available discourses (Riessman, 1993; Riessman, 2003). Member checks are useful in that the participants themselves can judge whether the account captures their experiences (Cresswell & Miller, 2000). Rather than employing concept of validity, some narrative researchers espouse trustworthiness – a concept that is linked to appropriate and coherent design as well as ethical and reflexive investigation (Wells, 2011). Creating trustworthiness is therefore an ongoing activity built into the research process. By clearly positioning myself theoretically, choosing epistemologically congruent research methods, employing transparent and ethical research practices, using reflexive and evolving analyses, and maintaining a clear understanding of the

study's purpose, I have made efforts to incorporate standards of good-quality research into this study.

3.5 Introduction to the participants and AL sites

I this section I present short introductions to the four participants and some details about their AL residences. Other details are presented in the case studies chapters and the findings chapters as relevant.

Mabel was a 95-year old Caucasian woman born in Saskatchewan. She moved to the Kootenay region of British Columbia at 19. For a time she lived in Ontario on an army base where her first husband was stationed, but she moved back to the Kootenays when he went overseas. She worked as a switchboard operator and also trained as an early childhood educator but did not work after marriage. She had two daughters from this first marriage. After she was widowed, she married a man who was also widowed and became a stepmother to his three sons. She was also a grandmother. Prior to Mabel's move to AL, she was living in an independent seniors housing complex in a city in the Fraser Valley. The AL is in a neighbouring rural town; one son lived very close and visited almost every day.

Mabel lived in a small AL residence of 32 suites, 10 of which were publically subsidized. At the time that she was looking to move, her cleaning lady recommended this particular AL where she sometimes performed as a singer. Although it had subsidized units, her family felt that her health was too poor to wait for a subsidized spot and they elected to rent a privately-paid suite, available immediately. The building had two levels; the upper level also had library and large patio. There was a bright, open common lounge and dining room on either side of an entry hallway, as well as a coffee and tea area. A private dining room off the common room was used

for holiday events but could also be booked by families for private functions. The doors had no entry or exit restrictions but Mabel said if she returned from her son's after 10pm she punched in a key code to open the main door. The town centre was approximately 1.3km away.

Helen was a 91-year old Caucasian woman. A daughter of Russian immigrants, she grew up on a farm in Manitoba near Medicine Hat with her ten siblings. Helen joined Air Force at the age of 21 during WWII. She was stationed in a personnel office in London, England until a year after the end of war when women's unit was disbanded. Afterwards, she took a "commercial course" and performed various office jobs until she settled in Surrey with husband in 1940s, where they raised a daughter and a son. After her children were in school, she did typing work and eventually got a job as the school secretary. Helen and her husband moved to a gated community in Okanagan after retirement. Her son lived in Lower Mainland, her daughter and a niece lived in a neighbouring community in the Okanagan.

Helen's AL residence was built in 2008 and offered both AL and residential care sections. I was able to walk right into the bustling lobby/reception/common area, but I did notice a resident sign in/sign out book while I was signing a guest book at the reception desk. When I went up to Helen's suite, I came across a door marked "Secure Unit", which is presumably why the main entrance could be left unlocked. There were 50 AL suites, some of which were occupied by couples. Helen paid privately; there were no publicly subsidized AL units. The multi-story residence is located on a main road close to a strip mall with post office and a drug store; Helen said she could walk there. There was a large common room with contemporary decor, a television and multiple seating areas, as well an open lounge for entertaining. The dining area was separate; Helen and I accessed it via stairs from her hallway on the second floor. The property also had a tuck shop, chapel and hair salon.

Rose, a 78 year-old Caucasian woman, immigrated to Canada from England as a newlywed in her 20s. Her husband left after a little over a decade of marriage and they divorced, leaving her a single mother with two sons and a daughter. She found a job as an after-school care provider and remained happily employed there until her retirement. She was a grandmother of four and a great-grandmother of one. Prior to her relocation, she lived in an independent seniors' apartment complex for 11 years and was very involved in her local community centre.

Ian was an 81-year old Caucasian man, born and raised in Vancouver. He was widowed, with a son and daughter who lived locally as well as a son and a daughter who lived in England and the United States, respectively. He had fifteen grandchildren. In his career he was a lawyer. Ian experienced a series of moves from home to hospital to AL to independent living before arriving in Forest Place.

Both Rose and Ian lived in Forest Place, a campus of care in a neighbourhood of Vancouver. Campus of care refers to a mix of independent living, assisted living and complex care/residential care units located at one site. There were 28 independent suites, 36 AL suites, and 112 complex care rooms. I describe the features of Forest Place in more detail at the end of Ian's chapter, as our final interview included a walk-through portion.

Chapter 4: Document Analysis: What is the Conceptual Story of Assisted Living?

The first stage of my data collection was to collect various promotional and regulatory materials about Assisted Living. My motivation for this was partly to begin to understand the context of what my participants may have expected, read about, or experienced as part of their relocation (Bowen, 2009). From a critical and social constructionist perspective, I also wanted to begin to unpack the dominant conceptual story of AL, based on the terminology, policies, ideologies, themes, and prominent messages found in the AL literature. This helped to create more relevant and informed interview questions, and also helped attune me to how the official, public story of AL might compare to the individual, contextualized stories of my participants. As Grenier (2012) suggests:

> "When local stories are set against larger interpretations of ageing and late life, the comparison between the official storylines of public policy and those experienced in everyday lives of older people provides glimpses into the coalescence or disjuncture between the suggested and the experienced." (p. 69)

4.1 Selection of documents

My main criteria in selecting documents were that they were publicly available and specific to, or relevant in, British Columbia. Within this, I sought documents that would be provided to individuals or their families by health care professionals and AL operators, or documents that were easily 'discoverable' by the individuals or families in the course of investigating AL. Arguably, some of the more technical documents I included, such as

legislation or AL operator manuals, would not be commonly accessed by older adults or their families. I felt it was important to include them, however. Partly this was because they have been made publicly accessible by virtue of their posting on government websites, and partly because they are an important component of the "communities of meaning" (Yanow, 2000) around the concept and purpose of AL. Indeed, much of the discourse used in the higher level policy documents has been reproduced in the language of handbooks and other publications targeted to older adult service users. While different groups (policy makers, AL operators, older adult residents) may interpret the core messages in these documents differently, there is a common set of terms and references within them that invite comparison.

There are several types of documents I did not analyze. For example, I chose not to conduct textual analyses of the government websites related to AL. Instead, I made note of the type of content covered on the three major government sites covering supportive housing for older adults (The Ministry of Health, The Province of British Columbia and BC Housing). I downloaded and reviewed any relevant publications posted and then returned to the websites to compare the publication information and website information. It was clear that most of the information on these sites is drawn from, and refers back to, the core legislation on assisted living (*The Community Care and Assisted Living Act*, 2002) and the policies of the Office of the Assisted Living Registrar, but is organized differently. The website information is typically organized to be read quickly and concisely and is sometimes repeated across pages according to search terms or related topics. It is written for older adults and families as well as assisted living operators and health care professionals, whereas the actual documents are typically targeted for one audience or another. Because of the repetition of information, and because it is often less

precise to cite information from websites as compared to traditional text, I chose to analyze the original, core documents or publications referenced there.

As well, I had initially intended to include an analysis of the actual assessment form used by case workers when determining eligibility for AL. I was able to obtain an 'off the record' copy of the assessment from a personal contact, but I felt I could not openly discuss or analyze it without having Health Authority permission. In part, this is because I would be violating my research ethics agreement with the Health Authority, and in part it was because my contact made it known that s/he was providing the document to me at professional risk. Therefore, I also requested a copy from the Health Authority. However, this request was met with a degree of hesitation. After conducting several participant interviews I decided to stop pursuing the assessment form because it seemed to be much less significant to the participants than I had anticipated. While they mentioned *being* assessed, none of the participants mentioned any of the details from the form or spoke about the initial assessment process in much depth. What seemed to make more of an impression with participants was the final interview just prior to move-in, where they met the staff and saw the building for the first time. From seeing the assessment forms in the course of my hospital social work, I knew that they are based on scores around physical and mental function, formal and informal caregiver support, and the degree of risk to the individual in the current environment so I was still able to ask pertinent questions and understand the general assessment process without specifically referencing the official form.

I also did not include internal staff, operations, or policy manuals for individual AL sites. Clearly these are very important in understanding the culture of assisted living and how administrative priorities can influence the day-to-day experiences of older adults in this setting. However, the focus of this study was to understand the experiences of the older adults

themselves. Because these documents are not available to the public, it would be very unlikely that participants would reference them in describing their experiences. As well, the Assisted Living Registrar and government documents cover many of the mandated procedures and policies that govern all AL sites. As I discuss below, I did include resident Handbooks from two ALsites that were able to give a picture of the values, expectations, and services that residents would experience. I felt that analyzing site-specific, internal AL documents would be better undertaken as a discrete future study, informed by the results of this project.

Ultimately, I included 18 documents and one website, sourced in several ways. From my experience in acute care with older adults, I knew of a publication given by hospital social workers to older adult patients and families that listed various private housing and home care companies (*The Care Guide*, 2012/2013), and I was able to obtain the most recent issue. Serendipitously, I found another national seniors housing and "retirement living" serial inserted into my *Globe and Mail* paper in the fall of 2012 (*Comfort Life*, 2012/2013). I was also directed to, or provided with, other documents through my contacts in a provincial Health Authority:

- A brochure on AL, given out by case managers to older adult clients and families
- The Ministry of Health and the Office of the Assisted Living Registrar publications for older adults, available online
- The Assisted Living Registrar's *Registrant Handbook* (2011) excerpts, available online
- A set of materials that the Health Authority gives to individuals after being placed on an AL residence waitlist, comprised of: a general resident handbook covering all subsidized ALs in the Health Authority; a cover letter; and an Assisted Living Application and Terms for Services document

I also performed simple internet searches on “assisted living Vancouver”, and “assisted living BC”. This generated results from private and public AL residences in Vancouver as well as in the general lower mainland and coastal BC; the Vancouver Health Authority website and its publications on subsidized assisted living; and the provincial government websites where I was able to follow links to key AL policies and regulations. As well, I requested that information be sent to me from the first two privately operated AL residences in Vancouver displayed during my internet search on “assisted living Vancouver”. Based on what Ian told me about the location and services of his first AL residence, I requested another package of information from a third, private AL that I thought might have been his. Because he could not recall the name of the property, I could not use the document as a source of data for his case. Nonetheless, it proved to be an interesting document as I will discuss below. Finally, I was able to include two resident handbooks from subsidized AL residences; one of the public AL handbooks was downloaded from the website and one was obtained through a participant at Forest Place.

4.2 Analysis

Since my goal was to construct a discursive story of AL and compare it to the stories told by participants, I elected to conduct a thematic content analysis that would include the context and function of the documents and the language used therein. I devised a set of questions that were drawn from literature on discourse and interpretive policy analysis (Gee, 1999/2005; Wood & Kroger, 2000; Yanow, 2000). The work of Grenier (2012) was helpful for its specific focus on the intersection of late life, transition, and ageing policy. Consistent with the critical and social constructionist approaches in this project, discourse and interpretive policy analysis direct the researcher’s attention to questions beyond the literal words on the page, towards broader

questions around the social messages, power structures, functions and assumptions of the texts. "Focusing on the messages that are articulated in public policy show how ideas about the lifecourse can become fixed into social practices that influence interpretations of ageing" (Grenier, 2012, p. 63). For example, the emphasis on health and function throughout many of the AL documents reflects the dominant perception of late life as a time of decline and infirmity. As I read the documents, I asked:

- Who is this document written for?
- What the function/purpose of the document?
- How is the document structured or organized?
- What is obvious or overtly stated/shown in the document?
- What is not said/shown?
- What are the assumptions in the document, about older adults or otherwise?
- What language or metaphors are commonly used?
- What are the dominant messages or themes in the document?

My goal in using these questions was to help me understand how AL has been discursively framed for Health Authorities and health care workers, older adults and families, and the general public. As Yanow (2000) explains, "frames direct attention toward some elements while simultaneously diverting attention from other elements. They highlight and contain at the same time they exclude" (p.11). Older adults may use these publicly available "frames of reference" to interpret and compare their own experiences with ageing (Grenier, 2012) and transition to AL.

In the following section I will present analytic summaries of the five different groups of documents:

1) Publicly distributed seniors' housing and care directories;

2) Information packages from private AL residences;

3) Provincial regulatory legislation and policy documents;

4) The website and documents from Vancouver Coastal Health; and

5) Resident Handbooks from two publicly subsidized AL residences.

Afterward, I will discuss how the themes and discourses across these documents come together to form a broader conceptual story of AL in British Columbia.

4.2.1 Seniors housing and care directories

Description and format

These guides are free, publicly-distributed serials that are published annually. As mentioned, *The Care Guide* is a booklet provided by (at least) one metropolitan hospital in British Columbia, to older adult patients and families who are considering alternative housing or care arrangements after discharge. It is produced by a Toronto company, Care Planning Partners, who offer provincially-specific versions. I was not able to find an electronic issue for the year I analyzed, but the current version is very similar in terms of purpose, layout and property listings (http://www.thecareguide.com/guide/BritishColumbia/). The *Comfort Life* print directory is one of several resources produced by a Canadian media company, Our Kids Media, who markets private schools, summer camps and retirement communities (http://www.ourkidsmedia.com/). It is a full-sized magazine format. Both the *Care Guide* and *Comfort Life* have online platforms that complement or extend the information in the guides. *Comfort Life* also produces an

e-newsletter that is sent several times a year. I was able to find a link to the entire online edition of the *Comfort Life* issue I analyzed, and I include the link here to be used as a reference to the pages and images I discuss (http://epub.comfortlife.ca/i/63074-10th-annual/66).

The directories are a combination of seniors' housing listings per province/city and information articles. It is important to note that in the issues I analyzed, all the listings in *Comfort Life* and the listings of prominence in the *Care Guide* are from privately-operated properties that elected to advertise with the publications. The publishers' statements of this are located obscurely in the publications, however, which could give readers the impression that the properties listed are the only properties available. Both directories provide an operator-written description of the properties, contact information, and a small photo of each that emphasizes flattering aspects such as grand entrances, modern apartment-style design, gardens, recreational amenities, and smiling staff and residents.

There is a slight difference in the terminology and organization used in each guide. The *Care Guide* uses the phrase "full spectrum of choice" (p. 10-11) to describe the listings, implying that older adults will be able to pick from a variety of housing and service options to best meet their preferences and needs. The properties are organized by care level (home care, independent living, assisted living, long term care and hospice). A short introductory article defines each level and briefly mentions the possibility of government subsidy "in some cases" (p. 10-11). The listings show specific services offered at each property, such as meals, laundry, housekeeping, "Alzheimer care", specialized staff, incontinence management or medication management. At the end of each section, there is a very small-print list of contact information for additional properties that did not advertise, but were collected by publication staff. This list includes both private and public properties, but this distinction is not made for the reader. Notably, this list is

the only *printed* collation of public assisted living properties in British Columbia I was able to find. The other listings seem to be available online only, via the Ministry of Health's Assisted Living Registry page, or on Health Authority websites.

Comfort Life uses the term "retirement communities" to describe the properties and simply includes the care levels offered as part of the listing details. Naming them as such makes a link to the idea of the third age, wherein individuals enjoy leisure and comfort as reward for their lifetime of paid employment. However, there is no discussion on what a retirement community is, or what the different terms (Independent Living, Assisted Living, Active Adult, Long-Term Care) mean in this context. This is an important point, given that the publication is national and provinces have a range of terminology for levels and types of care. The listings also include prices per month, where provided by the operators.

Target audience

The articles in both publications are written for older adults as well as their children. The editor's foreward to the issue *Comfort Life*, for example (p.4), switches audiences from paragraph to paragraph; one is directing single older women to an article on financial planning and the next is addressing children about how to have "the talk" about relocation with parents, with the help of articles in the issue. The *Care Guide* tends to use passively-phrased or simultaneous "seniors and their families" language to reach both audiences. Both publication covers feature middle-aged, Caucasian daughters with their able-bodied parents (a father on the *Comfort Life* cover and a mother on the *Care Guide*). While it does not reflect the multiethnic population of Canada, it does reflects the reality that daughters are often the family members who take on the care of their ageing parents.

Beyond this, the articles and advertisements speak to a particular socio-economic class. For example, there is an assumption of technological comfort and accessibility throughout the guides. The publications' web addresses are a runner on every page, many property listings offer virtual tours, several advertisements and property listings have smart phone QR scan codes, and one prominent advertiser in the *Care Guide* is Zoomer Wireless, a mobile phone company that specializes in cell phone plans and adaptive cell phones for older adults (p.21). This in itself is not unusual, given the recent growth in internet and smart phone-driven marketing, but when it is combined with pages and pages of advertisements for upscale, private residences and private-pay homecare services, it can be seen as targeting older adults who are active consumers and who have more income available for such amenities. It also references the popular language of 'zoomers' (baby boomers with 'zip') and consumer lifestyles. A *Comfort Life* article on financial planning, with its language of "investment portfolios" and "risk tolerance" provides this quote: "There is no reason why a senior woman, regardless of her marital status, needs to retire into poverty" (Irwin, 2012, p. 47). Such as statement negates the financial precariousness faced by many women in Canada. Unequal rates of pay, gendered patterns of job insecurity, years spent caring for family, and experiences of disability, immigration, and abuse can affect a woman's access to the paid economy and financial independence.

Content analysis

The articles focus on themes of knowing when it is time to move, downsizing and preparing for moving, and choosing personally-suitable accommodation. The listings for properties then serve as the solution to the problem of relocation. As one two-page spread asserts: "Your home is just walls. If it's not fitting your need, you need to find new walls" (*Comfort Life*, pp. 12-13). This comment minimizes the emotional connections people have to

their homes and neighbourhoods, and does not recognize the effort and resources it takes to make such a relocation. The core set of articles in the *Comfort Life* publication are based on the themes of "the seven pillars of a fulfilling retirement": social, environmental, spiritual, sexual, emotional, physical and intellectual (p. 7). Each pillar is addressed with testimonials from older adults living in the featured private-pay residences. The language of the articles draws heavily from active/successful ageing discourses, particularly the notion that individuals should take steps to prevent decline: "...idleness and social isolation are the enemies of healthy ageing" (Workman, 2012, p 10).

The *Care Guide* is arguably broader in its target audience due to its inclusion of a spectrum of both public and private care information, Health Authority contact numbers, and a list of national, public resources for older adults. Yet both publications demonstrate a conflation of neutral information with articles of promotional benefit to a private company. The *Care Guide*, for example, has several feature articles that ostensibly provide information about health issues, mobile phone providers for older adults, and how to decide when to move to seniors housing. Yet these 'articles' have actually been written by companies who stand to benefit from providing this information, such as home care service providers, a cell phone company, and housing operators. In the case of the *Comfort Life* article mentioned above, different housing operators are embedded into the happy narratives of older adults who have relocated, thereby providing additional advertising for the companies. Less critical readers might easily interpret these types of advertising articles as unbiased, researched information.

Visually, the images from the articles and advertisements complement the themes presented in the articles. In the *Comfort Life* publication, colourful photos of happy residents (exclusively Caucasian) socializing and laughing with spouses, peers, pets, children and

grandchildren suggest that assisted living could be just like being at home. Photos of older adults exercising, or the groomed grounds, cozy lounges, and grand entrances suggest that perhaps assisted living could even be a little bit better than home – more like a resort. As one quote states: “This place is like the Ritz. There’s always something going on” (Comfort Life, p. 27). One memorable photo (pp. 40-41) shows five well-dressed and smiling women around a table set with a white table cloth and full dinner service, being served sushi by a chef. They look delighted with this exotic and classy offering. The publication is called *Comfort Life*, and these images depict just that.

The images in the *Care Guide* are smaller, because of the booklet format of the publication, and fewer, because of the emphasis on property and service listings over articles. Yet they reflect the overall theme of the publication towards care, as its name suggests. Photos of older couples, or older adults with their children (again, exclusively Caucasian) are prominent. The posing suggests intimacy and caring: heads bent towards each other, bodies in embrace or with hands showing a caring touch. Advertisements for properties outside of the directory listings show images of dining luxury, modern and tasteful suites, and residents in happy groups.

Table 4-1 Seniors housing and care directories

Assumptions	• Readership is middle to upper class Caucasian or culturally Canadian • Private-pay properties are the standard • Older adults have the support of their families and other resources when relocating • Personal choice will determine where a person moves; shopping around for the right fit is possible (ex. checklist for touring is included in the *Care Guide*)
Dominant discourses/messages/ themes	• Preparation for decline; moving is inevitable so do it now, on one's own terms • Health and safety are better met in AL /retirement community • Where one lives and ages is a choice • The third age as a time of pleasure, comfort, relaxation and reward • AL as combination of home and resort & ready-made community • Active/successful ageing
What is not said	• Minimal explanation/acknowledgement of public system of care • Functional assessments are still a part of entrance in private residences – not all is up to choice and finances • Ageing in place is not strictly possible as there are limits to care levels in both private and public AL

4.2.2 Promotional material from three private AL operators

Description and format

I received property information for each of these private AL providers promptly after completing the online request forms. Property A sent an email brochure. At the time I requested it, I did not know that the property was one of the few private AL residences that contracts with Vancouver Coastal Health to provide some subsidized units. Part of the research agreement I made with Vancouver Coastal Health was that I would not name AL properties; therefore I cannot include the brochure in the appendix. Property B mailed a larger information package containing a folder with various leaflets and a handwritten card from the sales associate inviting me to contact her for a tour and lunch. Property C also mailed a similar folder of information about the property, along with a welcome letter and invitation for a tour. All three properties are located in Vancouver. Properties A and B and are operated by private Canadian companies with multiple retirement communities across the country. For reasons of copyright, I will not be including the images or text from these advertising packages.

Target audience

Property A avoids addressing any particular reader, so as to be applicable to older adults and their families. Property B is directly targeted towards older adults, with the cover of the folder incorporating the words, “My Life” into the title. For both properties, the images of residents are nearly all Caucasian. Staff, in the few images where they are depicted, are similarly Caucasian. In neither case do the images represent the multiethnic population of Vancouver. Property C is targeted to the “prospective resident”, with invitations for family and friends to be involved in the resident’s life and care at the property. Images in this package depict some racial

variety, although the residents are Caucasian and the staff are visual minorities. All three of the packages reflect an upper-class target audience, as I discuss below.

Content analysis

The content of the packages from properties A, B and C share a particular emphasis on refinement and luxury. Property A, for example, has chosen the image of a smiling older woman and young woman (both Caucasian) raising teacups in a toast for the cover of the brochure. Inside, photos feature the scenic view from the property, a smiling older Caucasian couple being served by a young Caucasian woman in a restaurant-like dining room, and a happy, well groomed older Caucasian couple reading together. Reminiscent of the discourses of active ageing and the third age, the text largely focuses on describing the "boutique apartments" and "trendy" neighbourhood, with its "exclusive" art galleries, shopping, and proximity to other "vibrant" districts. The adjacent medical centre is included casually in this list of amenities. Mention of actual care services is secondary. Staff provide "the best of service and caring", but the degree and type of caring is vague. The parent company is described in the last section as offering a "full spectrum" of housing types across their various properties, but it is not clear what care is offered at *this* property. The slogan on the cover is "So nice to come home to."

The extensive information package from Property B emphasizes a total retirement "lifestyle", not just the 'housing plus support' concept of AL. There is minimal mention of the word home; just one paragraph of the Building and Suite Features leaflet mentions "rental and condominium homes." Instead, the package emphasizes services, amenities and choice ("If it's your choice to make the most of your senior years, then [Property B] can help you make your choice a reality.") The leaflet describing the owner operator vision explains that this company has a "commitment to cultivating and expanding the most positive aspects of aging and

maturity." Portrait-style, black-and-white photos of 10 older adults (five women, three men and a heterosexual couple) are used on the cover of the main fold-out booklet in the package; one woman and one man are Asian and the rest are Caucasian. The booklet includes four pages of testimonials from attractive, able-bodied, young-old Caucasian individuals who may or may not be actual residents. A man, an "ex-food critic", wears a leather jacket and speaks to the quality of the food. A woman, a "yoga instructor", speaks to the health and wellness amenities that include personal trainers and a brain fitness program. Another woman, an "actress", is quoted as saying that she feels "more engaged in life than ever." She makes use of the in-house travel service and finds her time freed up by the housekeeping staff and personal concierge. Also included in the package is a floor plan showing amenities such as the pub, classroom, restaurant (*not* 'dining room'), fitness centre, spa, internet cafe, creative arts centre and library. There is also a sample monthly calendar of events, which includes movie nights, walking club outings, shopping shuttles and day trips, knitting, relaxation classes, lectures, art classes, brain exercises, hiking, birthday teas, yoga, happy hour, a current events group, fitness and strength classes, and poker night. Other brochures discuss the amenities of the newly developed neighbourhood in which the property is located. There are no images of children or grandchildren in the package; rather, the emphasis is on individual preference and priority.

The concepts of self-directed active ageing and the third age of leisure and reward are therefore prominent in the material. As with Property A, the discussion of care, or care needs is secondary. The message seems to be that Property B will manage resident's bodies and "design a lifestyle" so that they are not bothered by the inconveniences of ageing. In one vignette, "Sarah" enjoys being free from the "hassles" of living on her own now that the property is "helping her" to "stay fully engaged in life." In another vignette about a couple, Property B is described as "a

community where assisted living services [can] be *discreetly* provided - without compromising the quality of life they've come to enjoy" (emphasis added). Care services are listed and priced separately from rental and dining costs, ostensibly to demonstrate their approach of providing "custom-designed" services, "instead of providing...a standard plan." Here, a "standard plan" seems to be code for public assisted living, thus encouraging prospective residents to think about the added cost as ensuring better service and more choice than public system. Yet with rental prices starting at $3,700 a month, paying $340 to $1,050 extra per month for care services is arguably well out of reach for many older adults.

Property C has a similar emphasis on luxury and "elegance", but with a much more prominent focus on 'care' rather than independence or choice. The slogan on the front cover reads "Providing the finest in seniors' care for over 45 years." The cover of the main pamphlet inside proclaims, "All the Comforts of Home. Luxury Personal and Intermediate Care for Seniors." Perhaps because of this focus on care and because of the apparently higher care needs of residents, the amenities highlighted in the package do not reference the neighbourhood or the cultivation of a "lifestyle". Instead the information is focused on in-house services and amenities, such as the professional services available (massage, dentistry, physiotherapy, podiatry, and aesthetics), and the type of food and care services. Also included in the package is what appears to be a resident handbook. In it are explicit directions on entry procedures, what personal effects to bring, a list of recommended clothing, instructions for adaptive aids and furnishings, a daily meal schedule, and a list of staff and services. In this way, it more closely resembles a standard residential care type handbook than the luxurious, independent lifestyle guide from Property B. The sample monthly calendar of activities also suggests more standard facility offerings, such as a walking club, music therapy, musical entertainment, crafts, happy hour, exercise classes, bingo,

tea, bus "adventures" and church services. Interestingly, the packet also includes a copy of the Residents' Bill of Rights (developed in 2009 by the provincial government to cover all types of residential care facilities for older adults; http://www2.gov.bc.ca/assets/gov/health/accessing-health-care/finding-assisted-living-residential-care-facilities/adultcare_bill_of_rights.pdf).

The emphasis on care is also demonstrated in several of the leaflets. For example, "Resident and Client Testimonials" leaflet is made up of letters from three family members expressing their gratitude to Property C and commending the "patient, understanding, compassionate" care from staff. The "Care and Food Services" leaflet uses examples to demonstrate the high quality in these areas. For example, the leaflet states: "We maintain a staff to resident ratio, which exceeds licensing requirements, ranking us among the highest quality of care in our industry." Regarding meals, the leaflet states: "Residents are offered the highest quality of food and service excellence. Let us take care of your nutritional needs and make dining a pleasurable experience."

But I found Property C to be an anomaly, and I struggled to include it in this analysis at all. The leaflet on care levels and rates shows that the operators are still using the term "intermediate care" levels I, II and III, as was the case in British Columbia until 2002. In addition, they offer "extended care", which is another name for complex care or long term residential care. When I worked in the hospital system, intermediate care III was considered to have been functionally the same as extended care, yet Property C has distinguished a specific level called extended care. AL, in the current definition and regulation, is considered to be one discrete level of care with a maximum of daily assistance hours and prescribed services. Intermediate care, at some of its levels, may line up with AL in terms of resident independence and care hours, but it is not strictly comparable. Importantly, intermediate care in private

facilities was not regulated, so there were differences in the naming of levels across facilities. Presumably because Property C offers higher levels of care, they also advertise 24-hour nursing care – also not standard AL policy under current regulation. If this property is, indeed, where my participant Ian went when he was discharged from hospital, I can understand his confusion around terminology for different levels and models of care (I will discuss this more in the findings chapters). For these reasons, I do not include it in the summary of private AL properties listed in Table 4.2 below.

Table 4-2 Promotional material private AL

Assumptions:	• Upper-middle to upper class residents; finances not an obstacle • Caucasian or culturally Canadian • Amenities and lifestyle are the prime attractors for moving; care needs are secondary • Care needs will be unchanging • Family are not/do not need to be involved
Dominant discourses/messages/ themes	• Independence • Personal choice, personalized/self-directed care • Older adults as consumers; AL staff there to serve • Third age retirement lifestyle- a time of leisure, reward, pleasure • Active ageing • Private, discreet, dignified care
What is not said	• Assessment of care levels is still necessary for entry; maximum care levels may apply even in multi-level communities • Residents can expect to pay more as their care needs change • Rules/regulations for tenancy and communal living still apply

4.2.3 Provincial regulatory legislation and policy documents

Description and format

This group of documents together form the core legal and policy framework around the provision and regulation of AL in British Columbia, particularly the *Community Care and Assisted Living Act* (2002). While the *Act* also covers legislation and policies for long-term residential care, child or youth residential programs, and residential mental health and addictions treatment facilities, I will focus here on the sections dealing with AL for older adults. The *Community Care and Assisted Living Act* sets out the legal definitions of AL and its services, establishes the requirements of registration to operate an AL, and distinguishes between AL and other types of care facilities. Yet the *Act* has been criticized by both the provincial Ombudsman (2012) and the British Columbia Law Institute (2013) in two key areas. First, AL residences do not fall under the auspices of the Residential Tenancy Act, which mediates landlord/tenant relationships. This leaves AL residents with little recourse when faced with rental increases or other rental-type disputes. As well, the distinction of "supportive" versus "prescribed" levels of service set out in the *Act* is vague, meaning that the distinction of care services in AL versus that provided in long term residential care can be difficult to strictly apply or enforce. However, the *Act* remains the fundamental text from which flow all other AL policies across the province, Health Authorities, and individual AL residences.

Another important function of the *Act* is to create, and give legal authority to, the Office of the Assisted Living Registrar (OALR) who can register, inspect and revoke registration of AL facilities in the province. The OALR has, in turn, published four publicly available documents: the *Registrant Handbook* (2011); *A Case Manager's Guide to Section 26(3) of the Community*

Care and Assisted Living Act (2007); *Information about Assisted Living for Seniors (n.d.)*, and two versions of a pamphlet on making a complaint for AL residents (n.d.).

Finally, there is a *Home and Community Care Policy Manual* (2012- 2016) available on the British Columbia Ministry of Health's Home and Community Care web page, which is nested under the general Health and Safety topic web page. This document covers the full spectrum of care from home health services to long-term residential care, but my analysis focused on the sections applicable to AL. This manual interprets the requirements of the *Act* as they are to be enacted and upheld within the Ministry of Health and across provincial Health Authorities. The purpose is to ensure that services are accessed and delivered in similar ways across the province. Specifically, the *Manual* directs Health Authorities to "provide information to the public about home and community care services, how to access the services and how to make a complaint" (1.A). Different sections have been updated between 2012 and 2016.

For reference purposes, I include the web links to these documents as I discuss them below.

Target audience

Although most of these documents are written in a technical and bureaucratic style, they are posted on government web pages meant to be accessed by the public. The web pages themselves are more casual in language and often summarize key points for the reader. Therefore, while the original target audience of the legislation or the policy/practice manuals would not be older adults, they are now being offered to this population as a source of information on AL. The other documents written by the OALR have been specifically written for older adults and use the language of "you" and "your" when addressing the reader.

Content analysis

1) Community Care and Assisted Living Act

(http://www.bclaws.ca/civix/document/id/complete/statreg/02075_01).

The *Community Care and Assisted Living Act* (1.1) defines an assisted living residence as:

> a premises or part of a premises, other than a community care facility,
>
> (a) in which housing, hospitality services and at least one but not more than 2 prescribed services are provided by or through the operator to 3 or more adults who are not related by blood or marriage to the operator of the premises, or
>
> (b) designated by the Lieutenant Governor in Council to be an assisted living residence

Hospitality services are further defined as "meal services, housekeeping services, laundry services, social and recreational opportunities and a 24 hour emergency response system" (1.1) Prescribed services are not specifically defined here, however, this list is available in several OALR documents (discussed below).

The AL section of the *Act* deals only with the legal requirement to register a property wishing to use the title of AL, and the power and jurisdiction of the OALR to register, inspect, suspend and cancel licenses of AL operators. A key directive provided in the *Act* is the requirement that "a registrant [operator] must not house in assisted living residence persons who are unable to make decisions on their own behalf" (Section 26.2). In reading the *Act*, the main distinction between persons who qualify for AL over long-term residential care seems to be the need for not more than two prescribed services and the absence of advanced dementia. Essentially, the *Act* defines what type of property can be called an AL residence and the legal parameters of service.

2) The Assisted Living Registrar's Registrant Handbook

http://www2.gov.bc.ca/assets/gov/health/accessing-health-care/finding-assisted-living-residential-care-facilities/assisted-living-residences/seniors-assisted-living/seniors-registrant-handbook.pdf

The *Registrant Handbook* (2011) provides a much more thorough description of the expected policies and procedures that AL operators must follow to obtain and maintain registration. Its purpose is clearly stated as setting out the operators' obligations according to the *Community Care and Assisted Living Act*, provincial health and safety standards, and OALR policies and procedures (Section 1.1).

The *Registrant Handbook* opens with a statement on the philosophy and core principles of AL, which operators are "expected to embrace":

> The core principles of assisted living - choice, privacy, independence, individuality, dignity and respect – derive from a recognition that adults, even when they need support and assistance in daily life, retain the ability and right to manage their own lives. (Section 2.1)

The limit to this right of self-determination, however, appears to be risk of harm to self or others. As such, assisted living operators have a duty to keep a "watchful eye" on residents, which is explained as being somewhat higher in responsibility than in independent or supportive living but not as high as in long-term residential care facilities (Section 2.2). This language of risk and safety is then woven through the rest of the document. The section on the entry and exit of residents, for example, repeatedly mentions that the operator is "not to house people who are unable to make decisions on their own behalf", unless there is a resident spouse who will agree to take responsibility for that individual (Section 5.2). Indeed, there is such an emphasis on

decision-making ability that there are five appendices devoted to different aspects of assessing it and determining who is or is not eligible for AL. In addition to setting out the parameters by which a competent spouse may live in AL with a spouse deemed unable to make decisions, the appendices outline the most pertinent legislative approaches to substitute decision-making. They also offer flow charts to help operators screen for who is eligible to enter AL, how residents should be monitored, and what steps to take with health care professionals and case managers should a change in decision-making occur. Further, the OALR also created a separate document for case managers on how to interpret and carry out the legislation around decision-making capacity and residency in AL (*A Case Manager's Guide to Section 26(3) of the Community Care and Assisted Living Act*, 2007), which is essentially a repetition of the Handbook sections on decision-making plus some specific actions that case managers should take (http://www.llbc.leg.bc.ca/public/pubdocs/bcdocs2011_2/486232/case-manager-guide.pdf). An interesting finding from the *Registrant Handbook* is that an operator cannot force a person to undergo an assessment of capacity, but if they feel there are concerns over risk and capacity and the person does not comply with a request to have an assessment done, the operator "should trigger the exit process by giving notice to the resident to end the tenancy" (Section 5.3, p.8). Operators therefore have the ultimate choice over who may live in their facilities.

Residents may also be asked to leave if they are exceeding the physical care levels provided by the facility, but there is much less clarity in the *Registrant Handbook* on how that is decided. Part of this decision involves determining whether a resident's needs for services are exceeding the legal service provision levels allowed by the OALR. The section on Personal Assistance Services attempts to differentiate between a "support" level and a "prescribed" level of care, using medication management as an example. If a resident's care needs increase to more

than two personal assistance services, they would be legally ineligible to remain at an AL facility. However, the AL operator may choose to offer some of the other personal assistance services at a less intense support level. The six personal assistance services allowable by law are:

> (a) regular assistance with activities of daily living, including eating, mobility, dressing, grooming, bathing or personal hygiene;
>
> (b) central storage of medication, distribution of medication, administering medication or monitoring the taking of medication;
>
> (c) maintenance or management of the cash resources or other property of a resident or person in care;
>
> (d) monitoring of food intake or of adherence to therapeutic diets;
>
> (e) structured behaviour management and intervention;
>
> (f) psychosocial rehabilitative therapy or intensive physical rehabilitative therapy.
>
> (*Registrant Handbook*, section 6.2)

An important point around prescribed and support services is that it is the operator, not the resident, who chooses the two prescribed services and any other support services to offer. I was surprised to learn that even though residents are not allowed to *use* more than two services at a prescribed level, operators do not actually have to *offer* all of the possible prescribed services to their residents. The Registrant Handbook states: "When you registered, you determined the one or two personal assistance services that you would offer at the prescribed level in your assisted living residence" (*Registrant Handbook*, Section 6.2). As the British Columbia Law Institute notes (2013, p.8), most operators have chosen to provide the first two services – help

with ADLs and medication management – meaning that choosing an AL based on best personal fit or tailoring services once there may not be strictly possible.

The section on Personal Assistances services is one of the shortest sections of the Handbook; it consists of only two pages. And yet, one of the directives in the chapter is that operators "must develop and maintain personal services plans that reflect each resident's needs, risks and service requests" (*Registrant Handbook*, section 6.2). Service plans are referred to throughout the *Handbook*, giving the impression that they are a cornerstone of service delivery and reference for residents and staff alike, but there are no templates or examples of what a service plan might look like. The *Handbook* makes reference to additional sections within the document called "tabs" or "policy tabs" where staff can find examples such as "Personal Assistance Guidelines." It is possible that a template for a service plan is included in one of these sections, but these tabs appear to be inaccessible from the public, online version. I was interested to ask my participants what they knew about their service plans and what role these plans played in their experiences of relocation.

The remaining sections of the *Registrant Handbook* speak to the prominence of health, safety, and risk in the legislation and administration of AL facilities in British Columbia. Sections cover medication management and administration policies; serious incident reporting; meal and dietary obligations from a health and safety perspective; food handling and safety; complaint resolutions in the case of health and safety concerns; and procedures for the prevention and control of infectious diseases. The emphasis is on the accountability of the AL operator for maintaining health and safety and the standardization of procedures for the purpose of regulation. This is important to understand, because The OLAR is able *only* to inspect for

health and safety; it cannot resolve tenancy or quality of service issues. Yet the provincial Residential Tenancy Office does not have any specific policies or practices for AL residences, and quality of service issues are up to the individual operator to resolve, leaving residents in a jurisdictional gap (British Columbia Office of the Ombudsman, 2012, pp.180, 187).

3) OALR documents for older adults and families

The final two documents from the OALR are meant directly for older adults and families, although it is not clear how they are distributed or made available to residents. The purpose, services, and limitations of AL are very much drawn from the higher level policy documents and legislation but are written in plain language. The first document is *Information about Assisted Living for Seniors* (2009; http://www.health.gov.bc.ca/library/publications/year/2009/Info_Assisted_Living_Brochure.pdf) It covers the different funding structures of private and public AL; the philosophy and core principles of AL; a description of hospitality and personal assistance services; a description of the possible staffing models in AL; move in/move out requirements; residents' rights and expectations of residents; a description of the role of the OALR and the types of complaint it will and will not respond to; a list of health and safety standards for AL facilities, and a reference to the OALR's directory of AL residences in the province. Mental capacity is again highlighted as a requirement for residency, along with the caveat that personal choice is respected as long as it does not pose a risk to self or others. Reference is made to documents from AL operators that residents must sign and adhere to – an occupancy/residency agreement and a services plan.

The second document has a short and long version: *Assisted Living Registry: Making a complaint*, (n.d.; http://www2.gov.bc.ca/assets/gov/health/accessing-health-care/finding-assisted-living-residential-care-facilities/assisted-living-residences/alr-making-a-complaint.pdf) and *Complaint investigation for residents of assisted living for seniors* (n.d.; http://www.health.gov.bc.ca/library/publications/year/2009/Complaint_Investigation_Brochure.pdf). They describe how residents can make a complaint to the OALR, and repeat the information from the *Information about Assisted Living for Seniors* document. By isolating the information about what types of complaints the office does and does not handle, it attempts to clarify and simplify the process for interested parties at the same time as it emphasizes the jurisdictional limitations of the OALR.

Visually, all three documents have large print and feature photos of older adults of varying abilities, age groups, and ethno-cultural groups engaged in different activities. Based on the clothing, hair styles and environmental cues, the residents depicted appear to be of more moderate income level than those featured in the private AL promotional material. Presumably this is to demonstrate that the OALR responds to the needs of all seniors across the province.

While the tone of the documents is respectful and informative, the underlying message is that AL is a service with expectations and limitations for both providers and service users. This is a very different message than that of retirement communities that are selling a lifestyle to older adult consumers.

4) Ministry of Health Home and Community Care Policy Manual (http://www2.gov.bc.ca/gov/content/health/accessing-health-care/home-community-care/accountability/policy-and-standards/home-and-community-care-policy-manual).

Content analysis

Although this document is publicly available by following links posted on the SeniorsBC page of the Ministry of Health website listed above, the intended audience is administrators of Health Authorities who must carry out the policies as specified in the *Manual*. Throughout the document, service users are referred to as "clients", which reflects more of a contract model of services than a medical model. Although the Health Authorities are providing medical care, this language may have been chosen to best capture the broad range of service users, such as persons with disabilities who manage their own portfolio of care providers or individuals who receive home care services but who are not 'patients' or 'residents' under the stewardship of the Health Authority. The impression given by using this language, however, is that individuals have the opportunity to choose service providers when there are, in reality, few low cost alternatives to home, AL or residential care outside of the Health Authorities' subsidized services.

Chapters relevant to AL describe: who the approved service providers are; general eligibility requirements of residents (citizenship and provincial residency, age, and health condition); how a person is referred and assessed; standards around complaint processes; expectations for Health Authorities to "measure and monitor improvements in quality of care and health outcomes" (3.A); the expectation that AL operators will negotiate residency agreements and create care plans for each resident; and a description of the specific policies for housing plus care model, which encompasses AL.

The *Home and Community Care Policy Manual* reproduces the focus of the *Community Care and Assistance Act* and the OALR publications on maximum service levels, mental capacity, and risk to self or others as grounds for refusing or terminating service. The care plan is again woven throughout different sections as providing a reference point for an individual's level

of function and as a tool to ensure that services are being delivered appropriately. But there are also several other sections that provide policies for day-to-day administration, outline further restrictions on service or address special circumstances. For example, three additional requirements that a potential resident needs to meet before admission to AL are: the need for *both* hospitality and personal care services; the requirement for an individual to be at "significant risk" should he or she remain in the current living environment; and the need to agree to pay the assessed rate for services and additional charges (5.B.1, p. 1).

There is special mention of the policies around couples in AL and what to do in cases where the relationship is terminated, or in cases where spouses die or have disparate care levels. For example, residents who have been living in AL with their spouse but do not require the care services are asked to leave within six months of the partner's death or transfer. Another topic is the regulation of absences from the AL residence. Residents may be absent multiple times in a year due to hospitalization or other specialized services, but they may not be absent for personal reasons for more than 30 days annually. This policy speaks to the expectation of infirmity in residents, the acceptance of a medical model of ageing, and the restriction on personal habits and pursuits in order to maximize the use of the limited and costly commodity of health care.

Finally, the *Manual* sets the AL monthly rental rates, allowable charges, included benefits, and chargeable items that are not included in rental rates. Health Authorities are to calculate a monthly rate by multiplying 70% of an individual's income or a couple's joint income "and then dividing by 12, subject to the minimum and maximum rate" (7.B.2 page 2). The minimum monthly payments are calculated based on the maximum amount of Old Age Security and Guaranteed Income Security that an individual or couple can receive. As of 2016, an individual's minimum monthly payment for AL was therefore set at $921.40; a couple's

minimum payment was set at $1485.40 (7.B.2 page 2). In Canada as of January 2016, the maximum monthly Old Age Security payment for an individual was $570.52 (https://www.canada.ca/en/employment-social-development/news/2015/12/canada-pension-plan-and-old-age-security-benefit-amounts-effective-january-1 2016.html?= undefined &wbdisable =true) and the maximum Guaranteed Income Security was $871.86 (https://www.canada.ca/en/ services/benefits/publicpensions/cpp/old-age-security/payments/tab1-1.html). For an individual receiving the maximum government security payments and paying the minimum AL rate, this would leave just $520.98 per month for other expenses. Regarding the maximum monthly AL rates, the *Manual* states only that it is "based on a combination of the market rent for the housing and hospitality services for the geographic area where the client is receiving assisted living services and the actual cost of the personal care services for the client" (7.B.2 page 2).

Operators are also allowed to charge a damage deposit of a half month's rent, as well as a surcharge for hydro. Other allowable charges include items such as cable or telephone connection and monthly fees, transportation, personal grooming services such as hairdressing or foot care, personal laundry service, parking, pet deposit, and guest dining or suite rental. One potential difficulty is that there are no maximum rates listed for the allowable charges, meaning that if an AL operator contracted with a particular service provider, such as a telephone company, who then raised their rates, residents could be faced with an unexpected cost. In the case of the included benefits, there appears to be no way to opt out of services that are perhaps not needed, such as meal service or activity costs for residents who prefer to take care of such things on their own. For low income residents whose monthly income may be funnelled largely toward rent and prescription medications, any additional charges could result in having to choose

what to go without in given month. Arguably this is not the kind of ‘choice’ intended by the foundational values of AL.

Table 4-3 Provincial regulatory legislation and policy documents

Assumptions	• AL residences will operate in good faith according to the legislation. • Older adults and families will be educated on the existence and purpose of the OALR (but by whom is not clear) • Moving to AL will not interfere with individuals' pre-existing routines and social /recreational pursuits • Individuals to manage own health and well-being as much as possible • Individuals will be able to afford extra charges for activities and services after paying for the monthly rental fee
Dominant discourses/ messages/ themes	• Legal framework for AL, jurisdiction of OALR • Obligations and responsibilities of AL operators and the OALR • Boundaries of service in AL • Focus on health, safety and risk • "Watchful eye", gatekeeping, surveillance by AL operators and case managers • Setting minimal mental and physical function levels of residents • "Care" refers to care of the body • AL is not meant for ageing in place; not a permanent home
What is not said	• Residents have the *right* to complain or make reports, but the OALR and the Ministry of Health have the *power* to decide to inspect, make reports, fine, revoke/reinstate ALRs • There are no obligations to regularly inspect facilities • AL residents fall outside the protection of the Residential Tenancy Act • Social well-being as a factor in health is not directly discussed; things like environment and programming are given minimal mention. • AL values mentioned briefly in some documents, but not focused on in depth or operationalized • "Choice": how much and over what is not entirely up to the resident

4.2.4 Vancouver Coastal Health Authority documents

Description and format

The documents I analyzed from the Vancouver Health Authority I approached for my study included their website pages on AL, a brochure on AL given out by case managers to interested older adults and families, and a set of documents sent to older adults who have been accepted to a waitlist for a publicly subsidized AL facility. This set included two letters and a general AL handbook that outlines the access to and provision of AL across the Health Authority. I included the Health Authority website in my analysis because it appears to be a main source of information on AL eligibility, access, and individual properties in Vancouver. If a person was not already connected to community support services or a case manager, I felt it would be a common place to begin for someone researching supportive housing options for themselves or for a family member.

Target audience

As expected, these documents are targeted towards service users, prospective service users, and their families. The use of "you" language in some documents demonstrates that the information is meant for older adult themselves. In others, the use of a question and answer format is used to convey details in a more casual and easy to follow style for the lay reader. For example, several chapter headings in the Vancouver Coastal Health *Subsidized Assisted Living Handbook* are questions, and the answers are in bullet points or short statements (i.e. What is Assisted Living?; Is Assisted Living right for me?; What assistance is available to me?)

Content analysis

1) Vancouver Coastal Health Authority website

http://www.vch.ca/your-care/home-community-care/care-options/assisted-living

In order to access the AL web page on the Vancouver Coastal Health Authority website, one must navigate to it either by using the search field or through a series of tabs (i.e.Your Health, then Seniors, then Assisted Living). Although the page has been redesigned in the last year to be more clean and simple, and has clearly marked options to increase font size, one would need to be comfortable with internet searches to be able to pinpoint the correct links and subject headings to quickly sift through the large amount of data on the website and find information on AL.

The main AL page makes a direct statement that AL "may be an option" for "independent people who need a little extra help with meals and personal care...particularly if you are living alone or feeling isolated." The page is further divided into sections on the types of accommodation, hospitality and personal care services, general eligibility requirements, and how to locate private AL facilities that are not accessed through the Health Authority. Information on cost for services and more specific information on eligibility are provided via links back to the general Home and Community Care Services page. There is also a link to the Health Authority's *Subsidized Assisted Living Handbook* and an invitation to provide feedback on care to the Office of the Assisted Living Registrar at the provided web page or phone number.

The final feature of this page is a list of links to AL sites grouped by geographic location. Clicking on Vancouver, for example, one can view a list of properties, their contact information, and a map of locations. However, it is stressed that "These sites cannot be accessed by calling the facility directly." Instead, one must visit the Accessing Services page and choose one of several main intake numbers according to one's city of residence. In this way, the Health Authority asserts its control as a gatekeeper to the resource of AL. There is more evidence of gatekeeping when attempting to view information on individual properties. Upon clicking the

links for individual AL sites, one is taken to an intermediate page that again summarizes what assisted living is and repeats the message that "Clients cannot access Assisted Living by contacting the providers directly. [They must] be assessed by a case manager at a VCH Community Health Centre for eligibility." Only after reading the text to find an additional link is one taken to the individual site's page. On this page are details such as building amenities, a brief description of the suite, services included, costs, philosophy of care, pet and smoking policies, neighbourhood and community amenities, and any language/cultural/religious affiliations. Eight of the ten subsidized AL facilities in Vancouver listed have their own external web pages. When I first began my research these were not accessible from the Health Authority website, but in the most recent version of the site these links have been included.

In summary, the website does have a reasonable amount of general information on the individual AL sites, but the organization of it encourages individuals to rely on the Health Authority for information and access from the outset.

2) Vancouver Coastal Health AL brochure

This brochure is unique in that it recognizes AL as a housing plus support option for older adults as well as "people with physical disabilities". This speaks to the broad legislation of the *Community Care and Assisted Living Act* (2002), where AL can also be provided for younger adults. Visually, however, the brochure only depicts images of older adults- being served in a dining room, playing a keyboard in a personal suite, gardening, and participating in a seated exercise class. Presumably, this reflects the predominant use of AL by older adults. The staff and residents are a mix of ethnicities and genders, which does reflect a heterogeneous reality. This brochure and the subsidized AL handbook below are the only documents I found that mention income level. One page of the brochure states that AL is "affordable for all people, regardless of

income" and the other specifies that AL is "for seniors with low income". While this may reflect the reality of residents in AL and the rationale behind subsidized rates, this is not a specification mentioned in any of the higher level policy or legislation documents. Information on eligibility and physical/mental care levels, services included in AL, and access via case managers is succinctly presented in bullet points. Instructions to call one of the community health centres for more information set a clear boundary for those who might be inclined to investigate individual properties on their own. This is in contrast to the invitation of private ALs to book personal tours and even enjoy a meal.

3) Vancouver Coastal Health *Subsidized Assisted Living Handbook*

http://www.vch.ca/Documents/Assisted-Living-Handbook-February-2016.pdf

This handbook expands on the practical details of AL that incoming residents would want to know such as eligibility, cost, who to call for initial inquiries and how the application process works, who AL is suitable for, and names of AL facilities in the Vancouver Coastal Health Authority. There is also a list of other contact numbers for seniors' services in the province, including the OALR. The language is less blunt and technical than the *Registrant Handbook* or *Home and Community Care Policy Manual* that were meant primarily for staff and administrators. For example, a comment in the side bar of the page on moving out carefully explains that:

> Occasionally, the health of an Assisted Living tenant improves so much, they consider moving to a more independent setting. By the same token, sometimes their health needs change and they need 24-hour professional care that is provided at complex care sites. (p.16)

Despite this gentle tone, the emphasis on limits to service remains. For example, in the frequently asked questions section, the issue of escalating care needs is posed in two separate hypothetical questions whose responses involve the possibility of moving to long term residential care.

Several other key policies are embedded in various sections throughout the handbook:

- that AL does not fall under the jurisdiction of the Residential Tenancy Act
- that changes to one's income will affect one's monthly rate
- that case managers are the ones to organize a tour of " a suitable" AL facility
- that final approval of the individual as a resident does not occur until *after* a person has been added to the waitlist and *after* another interview with the AL operator and AL case manager (not one's own case manager)
- that turning down a suite when it is offered results in being removed from the waitlist entirely
- that if a person "choose[s] not to participate" in the meals and social programming, he or she may be asked to move out
- that a resident is not permitted to privately purchase extra care related services
- that a resident is not permitted to attend any previous day programs

As mentioned, the first point is a serious legal gap that has been specifically mentioned by the Ombudsman in her recent report of seniors care in BC (2012), and also by the British Columbia Law Institute (2013). The points about tours and waitlists indicate that it is not simply a matter of individual choice to move into one's preferred AL facility, and that there is some degree of uncertainty in the process until final approval is granted. The last three points suggest

that, although AL residents are encouraged to be maximally independent and maintain individual routines and relationships, the AL facility is expected to replace several areas previously under the individual's control. Yet, given the lack of attention paid to social programming in the higher level policy documents, It raises the question of whether the social programming in AL facilities is as extensive or well-developed as it could be.

Throughout the handbook, there is an interesting and ongoing juxtaposition of organizational structure with messages that uphold the notion of AL as an environment of choice. One page in particular describes the decision to relocate as "a personal decision, and you must feel comfortable with your choice" (p.7). It states that, "ultimately, Assisted Living is all about choice and maintaining your independence" (p.7). The sidebar comments, however suggest that potential residents ask themselves whether they are "able to live in a congregate setting where you will have your meals with other tenants and be expected to participate in social activities", and whether they will "abide by the 'house rules'" (p.7). Elsewhere in the handbook, there is a checklist of questions to ask on a tour (pp.12-13), suggesting that the older adult has a degree of control over where they choose to live. On closer inspection, the proposed questions are less about finding personal fit than they are about collecting information about the rules and organization of the AL (ex. parking policies, laundry room usage, the policy on tenant insurance, where the activity sheet is posted).

Finally, there is a page on how to make AL "work" for the individual (p.17). Advice includes being tolerant of new experiences and individuals; getting involved with "your new community" and the activities there; maintaining relationships with family and friends; and expressing personal preferences to staff. This section also contains several references to AL as a possible home: taking time to settle in to a "new home"; bringing cherished objects to make the

suite “feel like home” (p. 17). While this advice is reasonable, it also suggests that residents themselves are largely responsible for how they adjust to the pre-existing structures of AL. The final piece of advice in the section is to “be tolerant and enjoy the new experiences” (p.17).

4) Health Authority letters to waitlisted applicants

These two letters form a key part of the package mailed to individuals in the process of relocating to an AL facility the Vancouver Coastal Health Authority. The first is a Client Application Letter indicating that an individual has been placed on a waiting list and for what site, but that they are not yet approved to move in. There are a series of next steps outlined:

- The individual’s case manager will contact the individual when his or her name gets near the top of the list. If a person has been waiting for a long period of time, or if his or her care needs have changed, the person may be required to undergo a reassessment.
- In the case of no change, the person is “invited” for an interview with the Site Manager of the AL and the Health Authority case manager responsible for that AL.
- The individual will be contacted within seven days with the outcome of the interview
- The individual then has 48 hours to decide whether or not to accept the offer
- If the individual accepts the offer, the individual and the AL Site Manager decide on a move-in date
- If the individual declines the offer, his or her name is removed from the list and any new applications will have a new waitlist date

The letter then indicates what else has been included in this package and directs the individual to contact his or her case manager with further questions.

What this letter does not explain is that the waitlist times can vary from several months to a year or more. If an individual is not sure that they will be accepted, he or she may not begin to prepare for the move until after the final interview. At that point, downsizing possessions and making moving arrangements for just weeks ahead could become stressful, with or without assistance from friends and family. The letter gives the impression that, once on the waitlist, the person is swept into the machinery and processes of AL and must adjust accordingly.

The second letter is actually a contract of resident/tenant expectations and terms for service: "There will ...be expectations of you that we want you to understand before you move in." From my contact at the Health Authority, I understand that this document is not actually signed until the time of the final interview at the AL site, but it is sent out ahead of time to "set individuals' expectations." The letter reiterates once again that a person is not approved to move to an AL until after this final interview. It explains that the Health Authority and the OALR have policies and procedures in place that must be followed. The terms of service incorporate these requirements, but in plain language. It also mentions the ability of an individual to make a complaint to the Registrar.

Despite the assurance at the top of the letter that the Health Authority wants the move to be a positive experience, my impression after reading all the terms of service was a sense of restriction, contractual obligation, and surveillance. The high level of formality caused me to wonder what effect this might have had on my participants' existing attitude toward the move. From a practical, organizational standpoint, there is value in covering contentious points and limits to service upfront, in order to minimize conflict when asking residents to move out or comply with policies. However, one can imagine that it does not help foster a sense of positive anticipation of the move, or the idea that the AL will be a "new home."

Table 4-4 Vancouver Coastal Health Authority documents

Assumptions	• AL is able to provide adequate social, recreational and care needs in house • High income older adults will pursue private AL • There are multiple suitable AL facilities in an individual's geographic area and the individual's preference will be a main factor in picking one
Dominant discourses/messages/ themes	• Gatekeeping through case managers and assessments for admission • Tentative language that AL "may" be appropriate, or that an individual "may" have to move out sets authority of AL and health care staff as final decision-makers • AL is for accessing housing and personal care • Establishing limits to service – mental capacity, physical care levels • Monitoring, surveillance. compliance • Choice and independence, within organizational constraints • Fitting oneself into the structures of AL
What is not said	• Details about social and recreational programming • Minimal positioning of AL as home • An integrated discussion of AL values within the information • What will the benefits of moving be for the individual? What might they look forward to?

4.2.5 Site-specific subsidized AL facility handbooks

Description, format and target audience

These two documents are examples of what public/subsidized operators give to their new residents upon moving in. They are in booklet format with tables of contents, and the AL address and main phone numbers displayed prominently. Both are printed in black and white, with no pictures except in the one handbook where there is a photo of the front entrance and photos of the persons who have made welcome addresses in the booklet. I found the first handbook, which I will simply call the *Tenant Handbook*, on the operator's main website. This is unusual, as none of the other AL sites in the Health Authority have made the decision to publicly post their resident/tenant handbooks .The second handbook I will call the *Forest Place Handbook*, because I obtained it from one of my participants. I will make further reference to it later, as it forms an important part of that participant's move-in narrative. In this section, however, I will simply provide an initial content analysis. The terminology used for older adult service users is 'tenant' in the *Tenant Handbook*, and both 'resident' and 'tenant' in the *Forest Place Handbook*.

Content Analysis

The main distinction of the resident handbooks is that, while they mention many of the policies that are mandated by the Ministry of Health, OALR, and Health Authority, they are also meant to provide site-specific details about organizational routines, services, amenities, and expectations. Another key distinction is the clear statement of the ALs' vision, mission, values, and care philosophies and the effort to integrate them throughout the handbooks. While higher level policy documents make mention of the underlying tenets of AL, their focus is on practical and regulatory details rather than the values of "choice, privacy, independence, individuality, dignity and respect" (OALR, n.d.). The *Forest Place Handbook*, however, foregrounds these

guiding principles and expands upon them in the address to residents on the first page. Interestingly, this is the only document to refer to *ageing* and not just older adults. The language is respectful and recognizes the inherent worth of "elders." The opening statement reads:

> Forest Place recognizes that aging is a normal human experience and the gradual fulfillment of the lifecycle...It is our belief that elders are not different or special people, but are individuals with his/her own uniqueness, who request only that we respect them as persons with intelligence, sense of worth, and dignity.

Further, the closing statement makes reference to the concept of home, where Forest Place is seen as "a beginning, not an end, as a home, not an institution." Two further addresses to the new resident, one from a board member and one from the Executive Director, make references to Forest Place as the individual's "new home" where the individual is the "newest member of [the] family." This conscious positioning of Forest Place as a home is not common in the other AL literature I reviewed, with the exception of private AL Properties A and C. Property B emphasizes lifestyle, and the regulatory and policy documents are focused on the functional legalities and operational responsibilities of AL as a provider of housing plus support. The *Assisted Living Application and Terms for Services* letter from the Vancouver Coastal Health Authority uses the word home, but more as a mechanism for introducing the letter: "Moving to a new home can be both exciting and stressful. It is important that you have as much information as you need to make an informed choice prior to moving "(p.1). The accompanying *Client Application* letter frames AL in a completely opposite way – as simply a "program" for which applicants are now waitlisted. As mentioned, the Vancouver Coastal Health's *Subsidized Assisted Living Handbook* uses the word home, but with the similar purpose of framing the experience of moving and settling in: "the time it takes to move to your new home will vary"

(p.17).On the other hand, referring to Forest Place as a home and linking it to family within the first few pages of the resident handbook sends an important message to new residents that Forest Place can be a place to settle and look forward.

Returning to the values incorporated in the individual AL handbooks, the *Tenant Handbook* also includes its mission, vision, and values, but these are based on principles of Christian faith and the Eden Philosophy (a culture change movement originating in long term residential care). Language throughout the document is respectful and encourages residents to collaborate with care providers and ask for assistance. There is some representation of the residence as a community of caring: "At [this AL residence] tenants and staff work together to create a caring, compassionate and dynamic community where people are meaningfully engaged, life is celebrated, and individual contributions are encouraged." While not invoking idea of the whole AL as a home, it seems to strike a balance between individuals living in their own apartments who also come together to create a shared community of activity and relationships.

Sections common to both handbooks include information on procedures during fires, evacuations and outbreaks of illness; smoking policies; building maintenance; pet policies; the 24-hour emergency response system; car parking; cable connections and payment; access to the building; and visitor policies. Regarding visitors, both handbooks state that there are no restrictions on visitors, but that after 10 pm noise is requested to be minimal. The *Tenant Handbook* includes a brief additional paragraph explaining that visitors who stay in suite may only do so for 14 days out of 12 months; additional time must be approved by staff. Both handbooks give information on accessing personal laundry services and on housekeeping services. Interestingly, the AL site that produced the *Tenant Handbook* allows residents to purchase additional, private housekeeping services. This appears to be in violation of the

provincial AL regulations, but there may be specific parameters that are not stated here, such as staying within a range of service hours or service types.

There are other small differences in the language around how services are carried out. Where the *Tenant Handbook* says it will "make an effort" to schedule housekeeping services at a time preferred by the tenant, it does not guarantee it. The *Forest Place Handbook* uses much more flexible language, even stating that a tenant's "personal preference and routines will be respected and honored" and tenants will be "assisted with cleaning *as required*" (emphasis added). Personal service plans are mentioned briefly in each handbook, with both ALs offering only medication monitoring or help with ADLs at a prescribed level. Again, the *Forest Place Handbook* takes care to weave in language that references the AL values such as "individualized" attention and upholding "dignity and self-esteem" during assistance.

Meals and dining expectations are also covered in the handbooks. The *Forest Place Handbook* assures the reader that "a pleasant dining experience for two meals a day [lunch and supper]" will be provided in the dining room. The "meal program" is meant to "encourage independence through offering tenants choices", and the "Hydration and Nutrition Programs" encourage proper nutrition and "proper fluid intake." This description is quite different from the emphasis on the cuisine and restaurant-like atmosphere mentioned in the private AL brochures. Interestingly, the *Forest Place Handbook* states: "We regret that we are unable to accommodate special restricted diets however the menu offers a variety of selections." This is despite the Ministry of Health and the OALR's assurances to the contrary. Finally, the *Forest Place Handbook* mentions that the "dining experience allows the residents the opportunity for rich social interactions."

The *Tenant Handbook*'s description of meal service is much more succinct and simply relays lunch, dinner and snack times and locations. Both ALs welcome residents' guests to meals, providing the resident advises the staff and purchases meal tickets in advance. Both handbooks also mention "tray service", which is a temporary in-room meal service for ill residents.

Social and recreational opportunities are mandated hospitality services for every registered AL in the province. The *Tenant Handbook* covers this very briefly, however. It mentions that there are "therapeutic and recreational activities as well as health and wellness workshops", and that individuals are "encouraged to attend programs and get to know your neighbours." Tenants are urged to volunteer and to provide input into activity programming via the Tenant council and Activity Coordinator. On the main floor, residents are encouraged to "enjoy the facilities" of a lounge with a stationary bike, TV and piano, a library that can be reserved for parties, a small kitchen, personal care "spa", and a patio with a garden. On each upper floor, there is a common living room, dining room and balcony. The onus appears to be on the new resident to participate and to make social connections, with the exception of one passage about moving in:

> Moving day is an exciting, but often stressful time. We try to make the experience as pleasant as possible and can introduce you to other tenants who may participate in your tour of the building and help make you feel welcome.

The *Forest Place Handbook* provides a more expansive description of the *types* of activities offered – social, educational, spiritual and recreational – but the language is otherwise vague. The resident is assured, however, that there is a "full calendar of activities" available at various times and for holidays. The rest of the section describes recreation areas that residents

may use in their own time, such as a recreation room, games room, art room, library and communal kitchen. There is also an in-house, non-denominational chapel.

The final handbook sections common to both AL facilities are those relating to Resident/Tenant councils and avenues for complaint. Resident/tenant councils are promoted as a way for residents to be informed and empowered members of their AL community and to voice concerns. Dates, times, and locations for each facility's council meetings are included in the handbooks. The handbooks also mention periodic consumer satisfaction surveys as a way to improve services. Should a tenant have a complaint that cannot be, or is not being, addressed at the council meetings, both handbooks describe a process of resolution that involves taking the complaint to successive levels of staff until the issue is resolved. The contact information for the OALR is also provided in both handbooks. The *Tenant Handbook* further describes what type of complaint the Registrar will respond to and directs the residents to the OALR's complaint resolution brochure that is to be found in their welcome packages.

Other sections of the handbooks are unique to their respective facilities. The *Tenant Handbook* includes a description of the conditions under which a resident may no longer be eligible to remain in AL. The *Forest Place Handbook* does not because it is a campus of care, meaning that residents would most likely move to a complex care floor instead of being relocated entirely. The *Tenant Handbook* also includes a section on signing in and out and the missing person procedures that result from unexplained absences. Residents are free to stay out overnight, but they are requested to inform staff so that medications or meals can be planned accordingly. Forest Place appears not to have this aspect of surveillance, but the handbook does assert that it is the responsibility of every resident not to escort other residents off -property. Presumably this relates to the presence of complex care residents who may be at risk for

wandering. One interesting section of the *Forest Place Handbook* specifically addresses alcohol consumption and the fact that it is "left to the discretion of each resident/tenant." This position is congruent with the Handbook's opening statement on the right of older adults to self -direction and their "responsibility for their own actions." Finally, Forest Place includes an 18-point list of "Elders' Rights and Responsibilities." The purpose of this section appears to be an application of the values and philosophy of the facility, but also a way of setting expectations for harmonious congregate life. The tenets are similar to, but not replicated from, the Resident's Bill of Rights passed by the provincial government in 2009 and included as part of the inserts from Property C's package.

From participant interviews and from the information given to me by my Health Authority contacts, it seems that resident handbooks for individual AL sites are given to older adults only after they have moved in. This is likely due to the admission process where a person cannot know before the final interview whether they are actually going to the chosen AL, but I cannot help but think that having a specific handbook for the AL ahead of time would be a very useful addition to the mailed package. Potential residents might have a better sense of the AL environment and could more accurately tailor their questions for the final interview.

Table 4-5 Subsidized AL facility handbooks

Assumptions	• The mission, vision, values and philosophy of the AL will translate into good staff practices and organizational culture • Residents have avenues to voice concerns (Tenant/Resident Councils; OALR) and will feel comfortable doing so; ALs are receptive and responsive to critique • While meal options will not be decided by residents, meals will offer quality and variety • Residents will find activities to participate in within the AL • Residents will find a place for themselves in the life of the AL
Dominant discourses/messages/ themes	• Speaking to the individual resident • More language around organizational values and resident rights such as self-direction, respect, dignity, individuality, and independence • Entering into communal life; settling in, adjusting *oneself* to fit the environment and routines • Relinquishing some autonomy to gain security • AL as offering "family" or "community" (at least conceptually) • Staff are collaborators in care and service
What is not said	• Limited mention of neighbourhood amenities, except as related to medical care and prescriptions • Vague description of social and recreational programming

4.2.6 Discussion and summary

Returning to the notion of frames (Yanow, 2000), the documents overall seem to present two different but related conceptual constructions of AL, which I will refer to as the **ideological frame** and the **service delivery frame.** The **ideological frame** is primarily promoted in the directories, advertisements, private AL promotional packages, and aspects of the individual AL Handbooks. This frame emphasizes the commonly held values of AL such as choice, independence, self-direction, privacy, dignity and respect. 'Choice' here relates to a consumer model of service, where a person not only *makes* choices in terms of where to live, but also *has* choices within the AL environment. 'Care', in this frame, is a relational interaction that is presented as dignified, respectful, discrete (private), and flexible. Residents are therefore portrayed as having power to direct their lives and care plans, in collaboration with the staff of the AL facility. Assessment, gatekeeping, and terms of service are deemphasized, which reinforces the notion that one may choose when and where one moves, and can live in continuity with life-long pursuits and preferences.

In the ideological frame, the environment is referenced both in terms of its physical design and amenities, but also in terms of its affective qualities. Affect is a term describing "how the world is known rendered meaningful through the body's sensorial capacities prior to cognitive reflection...Simply put, in terms of an experience, affect is a vague but intense 'atmosphere'...registered...in an instant" (Andrews, Evans & Wiles, 2013, p. 1351). By describing AL residences as home-like, luxurious, warm, welcoming, vibrant, or being a close-knit community, AL is ideologically linked to positive affective associations. In the case of privately-operated AL residences, the promise of a carefree, stimulating and self-indulgent lifestyle echoes the notion of retirement as a third age. The connection of AL with physical care

is downplayed as a reason for relocation. The subsidized AL handbooks do incorporate a discussion of care and care plans, but weave the language of affective values into the writing.

Although the OALR includes an official statement on the values of AL in their *Information about Assisted Living for Seniors* (2009) publication, their *Registrant Handbook* (2011) is actually more focused on the practical and organizational aspects of AL. This is typical of the second frame, the **service delivery frame**. Here, AL values may be referenced in relation to specific policies, such as maintaining residents' privacy with lockable suites, but they are not a central discourse. The documents in this group are comprised of *The Community Care and Assisted Living Act*, the OALR and Ministry of Health publications, and the Vancouver Coastal Health Authority website, handbook and letters. The subsidized AL handbooks are also part of this group, because of their need to cover the practical details of living in an organized environment. In the service delivery frame, AL is consistently described in terms of its core structure and purpose: housing plus support, the provision of two support and five hospitality services, suites with lockable doors, functional requirements to move in/move out, and the key role of the personal care plan and ongoing assessment.

'Choice' in this frame is more about whether an individual is competent to make 'good' choices, and less about what the AL residence offers. Amenities and recreational opportunities, for example, are cursorily discussed; meals are referenced mostly in functional terms such as nutrition, attendance, and dining times. The emphasis on function, risk, and safety also suggests that there are certain limits to choice in AL. The terms of service, for example, require prospective residents to submit themselves to the expert gaze of AL and other health care staff, who determine who may enter and who may remain. The concept of 'care' is then shifted from a relational or emotional interaction between people to service items on a contract that both justify

the right to be in AL and serve as a marker of decline. Where the ideological frame downplays the role of organizational rules or structures the daily lives of residents, the service delivery frame is very focused on explaining regulations and service limits. Power here rests with the AL operator, but the residents may be consulted in a structured fashion through required care plans or participation in resident/tenant councils.

When viewing the ideological frame and the service delivery frame together, the conceptual story of AL that emerges reinforces the critical literature on AL, which suggests that there is some tension between the values of AL and the functional operation of AL residences. Documents like the subsidized AL handbooks, however, show that at the level of the individual AL sites there is an attempt to integrate both these frames into the day to day operations and environment. After reviewing the available documents, I was curious to know how the ideological and service delivery frames would be incorporated in the narratives of newly relocated older adults. How would their expectations and experiences of AL have been shaped by what they read or knew about it before moving? Did they also experience a tension between the values and the organization of AL? What would their stories illuminate that had not been included in either frame?

Chapter 5: Rose: Doing Something and Feeling Useful

I certainly didn't want to leave where I was.
Most of my life then was the community centre.
Suddenly, my health took a turn.
My lifestyle changed completely.
I couldn't go on
worrying about the children worrying about me.
So that was that.

There was only a choice of two.
Couldn't put your name on both,
Couldn't go and see it until you'd applied.
Ridiculous!
I waited almost a year;
Then a phone call- "You're in."
And suddenly realized -
Putting a bed in a different building is one thing
but what about the rest of it?
What about friends you've had for 13 years?
I chose *not* to think about leaving.
Because that, in the end, was the answer.

The mountain has always been my dream.
I was *so* amazed at the accommodation.
Eighth floor, with the most perfect view of the mountains.
The walks -
They'll just be a different type of beauty.
You've got your water.
You've got your trees.
But now you've a mountain as well.
So, alright.

I have to say,
I shouldn't have been dreading walking down.
All you've got is a piece of paper:
Welcome to Forest Place. Your table number is 25.
I went to one table,
Said, could you help me?
"You can't sit here. You're not allowed."
So my first impression was
I can't wait to go back up to my room.
I don't need to be part of this.

Everything in the booklet:
the expectations, the principles, the values.
They're words, that's it. They're words.
There's things I just can't do.
I can't eat the food.
The activities are all one level.
The atmosphere is not right.
Walk in and close my apartment door,
Then I'm fine.
It doesn't make it right.
It doesn't make it home.

I was frustrated.

Then I went to England.
When I came back, suddenly there was a lot of work to do.
I *really* look forward to those committee meetings.
What I've gained is feeling
I've still got things I can do.
I feel as though I'm back in the community centre working;
Doing things that I feel need doing,
Helping when I can, more and more.
It's no good complaining if I don't offer a solution.

5.1 Introduction

I first talked to Rose over the telephone. I had anticipated the need to explain the study more to her and to reassure her about confidentiality before gaining her verbal consent, but Rose had already made up her mind and had contacted me to set up our interview. I was struck by her warm tone and upbeat energy. She elected to meet in one of her favourite coffee shops close to

her AL residence, Forest Place.[5] When I entered the coffee shop, she waved to me straight away and even reached up for a hug. She had chosen a particular spot to sit, out of the sunlight, because she had rheumatoid arthritis and could not tolerate heat. At times it was difficult for me to follow her narrative, because our seats were located next to a stereo speaker and Rose had a low, soft voice. However, my field notes and transcription software, alongside her animated storytelling, were valuable in helping me transcribe the almost four hour interview with very few points of lost data. Going over the consent form, Rose indicated that she was very comfortable talking about her experiences at Forest Place ("They *know* I'm going to say what I feel"), and mentioned that she had even received a letter from the residence that gave her "full permission" to say whatever she wanted to say.

Rose's motivation for participating was directly linked to her own moving in experiences and her desire to bring about the improvements that she feels would have made her transition more positive. She agreed to take part in the study around the same time as she had agreed to take on a project initiated by Forest Place to recruit AL residents to improve the resident Handbook. During our first telephone conversation, Rose specifically said that she wanted to tell her story so that "no one else would have to go through what I went through."

At the time of our first interview, Rose had been at Forest Place for just five months. I began by asking her to tell me the story of her move to AL and she gave her account in great detail, from beginning to end. At points the narrative was suspended to introduce sub-narratives, clarify points, or answer questions, but Rose always picked up the thread and moved the story

[5] As per the consent agreement, participants were free to choose the location of their interviews. Rose always chose a coffee shop near Forest Place. We did spend a great deal of time discussing the physical environment and her use of common areas via interview questions. I was able to see a suite and the common areas of Forest Place through my interviews and tour with Ian, and I incorporate that data into his chapter.

along. We met three more time over the course of a year, always in a coffee shop close to Forest Place. These interviews were always an hour or more and focused on clarifying details of Rose's narrative, exploring recurring themes, and receiving updates on Rose's life in Forest Place. Even though her life was the subject of the interviews, Rose had a remarkable ability to make me feel as though she cared about me and my life in return. Going over the interviews, I began to see that Rose held a multidimensional concept of **caring** that was integral to the decisions Rose has made in her lifetime and to her sense of authentic self.

In the first sense, Rose simply derived pleasure from caring about people. Without prompting, she was able to articulate that she has a natural orientation toward caring and connection as part of her personality. Although she said that she "never needed to have very, very close friends" because she had that type of relational intimacy within her family, she nevertheless enjoyed "knowing and caring about a lot of people." The relationships she was able to forge in her first year of living at Forest Place and in her new community had a direct influence on how comfortable she felt there. In the second sense, caring was a core value that Rose upheld in daily life. Partly, this was reflected in Rose's belief that "if you're going to do something, you do it correctly or you don't do it at all." Doing less than one's best, for oneself and for others, implied a lack of care. By extension, Rose had a particular concern with how daily routines, comportment of staff, and the organization of the physical space of Forest Place did or did not demonstrate care for the residents and staff. This relates to the third dimension of care in Rose's narrative, in that Rose embodied her value of caring through her acts of service. As we read in the poem, most of Rose's life before her move to Forest Place was being involved in the local community centre – not so much as a participant, but as a key volunteer. She demonstrated care for her community members by developing and delivering programs that

nurtured and supported participants. Until Rose found a way to replicate this type of purposeful activity within Forest Place, she was discontent with her life there.

A second major theme within Rose's narrative was **doing**. This theme partly encompasses her drive to perform acts of service, but also reflects the importance Rose placed on proactive problem-solving, managing her arthritis, pursuing social and recreational activities and maintaining her independence. Even in our interviews Rose often became very animated, acting out characters and voices and providing her reflective commentary on the situations she was describing.

Below I will introduce Rose and present a summary of her relocation narrative. Within these sections I will highlight how the themes of caring and doing are woven into Rose's story.

5.2 About Rose

Rose was a petite, 78 year-old Caucasian woman with short, silver hair and a ready laugh. She was born in England and grew up in a close-knit family of two sisters, a brother, and parents whom she described as "very loving people, and very considerate." Her maternal grandparents also lived out their lives in a little cottage built for them on the family property by Rose's father. Rose credits her parents for instilling in her the value of caring for others, particularly her father. Several anecdotes demonstrate her father to have been very "forward-thinking", compassionate, and altruistic for the time. For example, Rose's father was a builder in their village. After the end of World War II, he employed several men who had been prisoners of war.

> So he had two men who had been prisoners of war, who were scared of *every* human being. *So* frightened, it was unbelievable. And then another one, he came back, and was completely shell shocked... [My father] just managed them so beautifully. And in the

> end, you know, we couldn't believe it...Within five years they were talking, and they would go and knock on the door and say to Grammy, 'Is the kettle on?'... And to think of them saying that before... it was amazing. (original emphasis)

Rose's father also took the step of approaching the village vicar "the minute the war was over" to set up an exchange of German and British youth through the Church. Rose remembered her father expressing that "you can't hate a whole country" and that "the only way it's going to stop, is if the generations stop it." Rose said, "He just got hold of that vicar and said, 'Now, look. You've got to start somewhere. I think the Church can arrange a friendship trip, and my three girls will be going.'" Rose's family therefore modelled caring as a value and as a social responsibility.

Rose and her siblings were also encouraged to travel and explore the world, and Rose had already spent time in Canada visiting her brother before she and her husband emigrated here early in their marriage. When her oldest son was 15, her husband left and Rose raised her children (two sons and a daughter) as a single mother. Although it was a very hard time for her, she still had the capacity for empathy:

> I think I was more sad thinking about the things that he would never see. The boys graduating. Getting married...[T]he more we got on with our lives, every now and then I found myself thinking, "You have no idea what you're missing," you know? And I found that very sad.

Rose says she simply dealt with it by "[getting] on with things." She took a job as a before- and after-school care provider; she spoke of this job very fondly. The hours were very long, but she "loved it." She recalled that "all those mothers were my friends" and they were "as important to me as the children." One of her most treasured possessions before she moved to

Forest Place had been a framed print given to her by the parents – clearly there was a mutual sense of caring established during her years of work there.

Yet the most important focus in Rose's life appears to have been her family, both near and far. From early in the first interview, Rose freely incorporated their anecdotes and voices into the overall context of her narrative. Her sons and daughter still lived in the metropolitan area along with several grandchildren. Both before and after her move to Forest Place, her children made a point to visit her as often as they could. They worked and travelled a great deal, but kept in touch with phone or video calls and email. She had regular contact with her grandchildren, even the ones living in England and Eastern Canada. And despite living in different countries, Rose's parents (now deceased), her siblings, and their children visited between England and Canada several times a year over the last 20 years. Her younger sister maintained the family property in their village, and, in the past, Rose would return at intervals to visit and give that sister respite from caring for her own children and Rose's mother and father. Since moving to Forest Place, Rose has been to England to visit her siblings twice. After the first trip, Rose laughed when she told me about how they all took turns in the wheelchair she rented when they needed a rest. The impression given was of a family that was emotionally and physically supportive, if not always geographically close.

As indicated, an ongoing part of Rose's life was actively managing her rheumatoid arthritis. She was familiar with the trajectory, because her father also had the disease and actually died from the cumulative side effects of his medication. Rose described it as a "travelling arthritis" that could affect different parts of her body from day to day, or even from hour to hour – "I can be talking to you now and by the time I leave, I might not be able to walk." Yet, she had creatively dealt with the inconvenience of this disease:

> Nine times out of ten, there's a way. And in actual fact, sometimes it becomes quite an interesting challenge! One of the kids had brought me a bottle of wine, going back several years. And it had a screw-top. [I] couldn't open it. And then I remembered nut-crackers. So I got my nutcracker! So you see? It does [become] sort of a game in the end.

Over the year that we met, Rose's arthritis progressed several times and eventually resulted in an additional diagnosis of osteoarthritis. There were days that she "couldn't control the pain at all", or where she couldn't lift her arms or move one or both of her feet. She had trouble sleeping at night because of the pain and because reclining made the symptoms worse. Through it all, Rose persevered with what she felt to be the most helpful course of action for her - yoga, exercise, and a nutritious diet. I found it very revealing that, when her arthritis progressed during the first year at Forest Place, she also took the initiative to ask her doctor to fill out the forms for medical marijuana use. She was not bound by convention or opinion (she actually did not even consult her children); she chose to investigate every available avenue. This determination in problem-solving proved successful for Rose, who found that the marijuana did relieve the pain enough for her to be able to sleep more soundly.

Another remedy Rose found helpful in coping with her arthritis was volunteering, at least until the point that she was unable to predict what her symptoms would allow her to do in a day. Volunteering "motivated" Rose to get up and get moving, which helped reduce stiffness and pain. But it was also an important outlet for her caring nature and her need to feel she was contributing. Part of what she gained was camaraderie with other staff: "Most of the time...we were working damn hard, and enjoying every moment of it." But she also gained satisfaction from the act of service itself: "At the [community] centre, it was the sheer enjoyment of the pleasure the other older people got, out of seeing rooms decorated with flowers on the tables

and...being taken out on trips." The sense of belonging she felt there extended to the wider community. She says she was never able to walk around her neighbourhood without someone she knew from her time at the centre walking up to make a coffee date, or "simply giving me a kiss." This reflection demonstrates the esteem with which she was held in her community and the social benefit Rose reaped from her hours spent volunteering.

5.3 Moving In

Rose was quite content, therefore, living in her Independent Living apartment in a suburb of Vancouver, volunteering and being involved with her family. Yet approximately 18 months before she moved to Forest Place, she had a particularly aggressive arthritis flare-up with unusual symptoms. This prompted her children to try and see her more often, on top of their busy schedules. "I said this is ridiculous, all it's actually is doing is making things worse to me. I worry [about them]. When I worry, then the immune system *isn't* coping. I'm going back to England... I'm taking a break from everyone "(original emphasis). She spent several months in England being cared for by her younger sister on the family property while the family doctor tried to stabilize her condition for the flight home.

When she eventually came back, she said that her symptoms were not much better and that her children were so "horrified" when they saw her that her daughter "immediately called in a case worker." Another of Rose's sisters, who had been living in South Africa, came to stay with her for the next several months. During this time, Rose and her family applied to an AL residence in Vancouver, the city where her children lived. I asked her why she chose the one she did, and she replied that the priority was to be as close as possible to her children.

> So whenever they came to see me, it meant at the end of a work day – and sometimes that could be eight, nine o'clock at night - driving across three bridges to see me, driving back. They'd done it for twelve years. It got to the point where...I almost didn't want them to come.

I asked if she did any research before making her choice, and she replied matter-of-factly that there wasn't much point, because there were only two in the neighbourhood closest to her family. As we can see from the poem, Rose still bristled at the fact that she was not able, as far as she knew, to visit either place before choosing to go on one waitlist - "You *don't know* until you walk into the place...I'm not talking about the furnishing inside. You *know*, in your heart, if you listen to yourself" (original emphasis). But Rose's family did what they could initially to help her narrow down her choices; she describes how her daughter and son-in-law drove around and ruled out potential properties based on what they knew Rose needed and preferred. Rose's particular worry with Forest Place, after driving by with her family one day, was that she had accidentally chosen a 'nursing home'. As mentioned, Forest Place was a campus of care, with independent living, assisted living, and complex care/long term residential care in different sections of one building. Her first impression upon seeing the main (complex care) entrance was, "What *have* I put myself into?" Without being able to tour the AL residence beforehand, she could not know that there was a separate apartment tower for the AL residents. Still, she tried to think optimistically after noticing the surrounding neighbourhood with its tree lined streets, beautiful scenery, shopping, and pedestrian friendly walking routes – "Nothing could be that bad with all these things around me, you know?"

Rose spent a year on the wait list for Forest Place, during which time her family arranged for a private home care company to come in and support her as needed. Rose says she had some

good days and found her functioning stabilized somewhat over time, but she did not allow herself to think about perhaps staying in her community because she knew the unpredictable trajectory of rheumatoid arthritis.

> That year was pretty good for me, activity wise. Then [my name] came up and I knew immediately I mustn't even stop and think about it. Don't stop and think about it. Don't think, that I'm doing this on my own, now I'm doing that on my own, I can wash my own hair...don't think about any of it. You don't know when it's going to happen again.

Rose eventually heard from her case manager that she should expect a call from Forest Place for a final interview. Her account of the interview process again highlighted the value she placed on caring and on family. She was demonstrably pleased that her family came with her to the assessment and paper signing interviews; she smiled when she told me that the Director of Resident Services had to look for a larger room in which to hold the first meeting because she never had so many family members at an interview. Her first impression of the Director herself was favourable, largely because the woman greeted Rose by name, had taken the time to read that Rose was a certified yoga instructor, and asked Rose if she would teach her yoga one day. Rose said this effort to get to know a little bit about her "was one of the high points" of that interview. By showing that she cared, the Director gained Rose's respect.

In contrast, Rose was put off by the case manager for Forest Place, about whom Rose said, "I got no feeling of warmth, disapproval, approval, attitude, couldn't be bothered. There was nothing." The case manager went over the official rules, regulations and policies of Forest Place and the Health Authority. Rose was unimpressed with this aspect of the process: "Everything she read through was in the booklet that I'd been given the year prior." The

paternalistic tone, as well as the case manager's impersonal demeanor, caused Rose to "just tune out."

The presence of Rose's family, however, and the burgeoning rapport with the Director, enabled Rose to feel sure that there were ways of being flexible within the rules. For example, Rose's daughter began to ask more detailed questions, such as what would happen if Rose wanted to go visit her sisters in England. Rose imitated the brusque tone of the case manager's response: "You're allowed to go for a week. Can't leave for more than a week at a time." At this point Rose's daughter reassured her by mouthing, "Don't worry." Rose smiled in recalling this, and said it was like her daughter telling her, "We will sort it!" So while Rose was hearing the official 'voice' of AL, she was able to filter it through her knowledge that her family would look after her and through her impression of the Director as a caring person.

Rose had a much more favourable impression of the actual suite – after viewing it, she made up her mind almost immediately. She says, "I was *so* amazed at the accommodation. Now, I'm not saying everybody's is like it. I don't know. But mine is *gorgeous*." The studio suite impressed her with its large windows, mountain view, ample closet space, large bathroom (shower only) with plenty of grab bars, neutral colours, full kitchen and laminate floor. Two features in particular were important for Rose. The first was a reasonable view. As someone who has experienced periods of being bedridden, Rose has an appreciation for

> ...how you feel when you're in a room and you know that you're going to feel comfortable there....The other thing is, what do you look at when you can't get out? And my biggest dread has always been to live somewhere where my living room or bedroom window faced um, an alley...

The way she described the view from her suite to me, it was as if she was painting it with words. She said that at the time she thought, "if I couldn't move, except to the bathroom and back, and I have to sit and look at this, nothing can be that wrong. *Knowing*, that, the children would be there, you know" (original emphasis).

The second crucial feature was a window that opened so that she could maintain a cool temperature for her arthritis. She suspensefully described how she was unable to open the window at first, and how her acceptance of the suite hung entirely on this test. When the case manager eventually got the window open, Rose said she and her daughter shared a fleeting look that Rose interpreted as "we were a go."

Consistent with the close relationships in her family however, she waited to give her final response until after she had talked with her children. In this portion of her narrative Rose described some tender moments with her daughter and oldest son, as they collectively realized what this move meant. Although they all agreed that it fulfilled Rose's most important requirements, it seems that they just then recognized the weight of the decision and the phase of life that Rose had now entered. With some tears, she recalled the conversation with her son as he drove her home.

> ...He said, "Just don't worry about it; we'll just get you home." And I said, "Well could you at least tell me what you think?" He says, "You can't ask me that question." And I said, "Well why?" He said, "Because I don't want you in *any* home"...So I said, "Well, I know that's true. But as it can't happen, what do you think?" He said," I think it was ok." (Long pause); (original emphasis).

At this point in the story, there is a shift from waiting and wondering, to actively preparing for the move. As the poem shows, Rose now began to realize the social cost of moving

– something she hadn't allowed herself to dwell on during her year on the waitlist. Not only would she be losing the activity and sense of purpose she gained from volunteering at the community centre, she would also be leaving her best friend Jane. Talking about saying goodbye to Jane and her community was the only other time Rose became tearful in the interview. Immediately after describing this loss, however, Rose shared how she began coaching herself to see the positives of the move, such as the new places to walk and the mountain view from her suite. Part of her preparation to move also involved strategizing with Jane on how they would maintain their relationship by means of email, telephone, and public transit.

With just three weeks before she had to move, Rose began to focus on the practicalities of relocating, such as downsizing her belongings. I did not expect this part of the narrative to be so extensive, but Rose described in great detail how she came to give away most of her possessions. It was important to her that items that still had value either functionally or aesthetically be placed with individuals who would enjoy or benefit from them. For example, she opened her kitchen to a neighbour to take whatever utensils she did not already possess; she made bundles of items that she "knew would be useful" for another neighbour to take on her rounds to homeless people; and a treasured set of prints was given to a friend who had always admired them. Rose indicated she felt glad to be able to give her this present and to know she could go see them from time to time. Going about downsizing in this manner seemed to be a way that Rose could take control of the situation and to perform one more act of caring for the community and people to whom she was connected.

The fact that she could not shift her large furniture until three days before the move, however, caused her a great deal of stress. Beyond it "breaking [her] heart" to take good furniture to the dump when she was sure someone could use it, Rose said that she was concerned

that if she could not clear the furniture, she would not be able to move in to Forest Place on the specific date and would lose her suite. In the last few days before moving, she found someone who promised to find homes for all of it, which she found relieving: "All I knew was, that *he* was going to look after that furniture, and I *knew* it would not end up in the dump. And, that it was going to be safe (original emphasis)." She said that the whole process of downsizing, and especially of worrying about the furniture, took a toll on her emotionally: "I think a lot of it was getting mixed up with, this is it, there's no turning back."

At this point in her narrative, Rose described an event that greatly influenced *how* she moved into Forest Place and her experience of her first days there. On the day of the move, Rose got up in the early morning, tripped on a piece of furniture in the dark, and fell in an awkward position. She laughed when recalling how she must have looked and how long it took to figure out how to get up, in light of the limited strength and mobility of her hands. Yet the fall was serious enough to cause real pain in Rose's hip that night, and for several days following she was not able to walk or stand. Because Rose's injury meant that she had a diminished physical presence in the move, Rose had to continually negotiate her authority throughout the process. In some areas she was successful, such as refusing the care aide's suggestions to go to the hospital, or assertively coaching her family members to arrange furniture where she wanted it. In other areas, Rose was clearly frustrated. For example, she described being "manhandled" when she was carried out of the car and up to her suite at Forest Place, at the same time as she recognized that it was done out of necessity. She was also unable to unpack in the manner to which she was accustomed.

> So, now, the *hardest part for me* [tapping the table with each word for emphasis] is sitting in that chair, and watching people put my stuff [in]. I have moved *many* times in

> my life with 3 children, and while they were at school, I have moved an entire *house*. *And* had tea [supper] waiting for them when got home from school. No one has *ever* unpacked any of my stuff. (original emphasis)

For someone who had learned to maintain a great deal of independence despite her arthritis, and for someone who so enjoyed organizing and maintaining her home, it must have been an unusual and uncomfortable position in which to be. At the same time, Rose genuinely appreciated her family's efforts to help her settle in and was able to consciously call upon her relational values in order to help her deal with this frustration. She remembers telling herself at the time:

> ... it doesn't matter. All it means is, next few days, you can simply move some from to one shelf or another, so you know, don't make a bigger deal out it. Yes, it'd be much easier to unpack them and put them in the right place, but people are here and they're helping you and they are happy with what they are doing. So forget it.

In this way, Rose was able to recognize what others were doing as demonstrating care, and then allow them the experience of feeling good about helping.

Rose's injury also had a direct influence on the type of interaction she had with Forest Place and its staff in the first few days. The afternoon of her move-in, Rose was visited by one of Forest Place's care aides. After an initial discussion over the injury and the offer of a walker, Rose said no one returned to see her for two days. This inattention is the crux of the dissatisfaction that Rose felt upon moving to AL, and which motivated her to share her story. The Forest Place Handbook provided to Rose had a phone number for residents to call if they needed assistance. Rose felt that even though she did not particularly need to phone because nothing in her condition had changed, the onus was on the *staff* to check in on *her*, given that

they were concerned enough to suggest an x-ray and a wheelchair. Because care and compassion were such a core part of Rose's way of life, for her to not receive such attention in a setting *specifically meant* to provide support and care seems to have been a real affront. She described a brief exchange on the third day, when a staff member "put her head in" the door and asked, "'Are you going down for lunch today?' And I said 'No, I'm not. I'm not feeling well enough to do that.' 'Alright,' she said. And that was that."

Rose had been able to get around her apartment and to make meals of the groceries her children had left, but she says she was beginning to feel "isolated." Characteristic of her tendency to face problems with action, Rose therefore decided that she needed to steel herself to go down to the dining room. I was surprised that such a seemingly social woman would be "dreading" visiting the dining room, but she explained that she is actually "quite shy." Rose had no idea of what to expect of her dining experience – "All you've got is a piece of paper saying, 'Welcome to Forest Place. Your table number is 25'." Her social anxiety, compounded by her injury and temporary use of a walker, meant that she was feeling physically and emotionally vulnerable when taking this first step into her new life. Adding to this was the perceived indifference of several staff and the hostility from some of the residents when she asked for help locating her table. "So my first impression was, 'I can't wait to go back up to my room. I don't need to be part of this'." Rose also discovered that residents from complex care, many of whom had dementia or cognitive impairment, dined with residents from AL. Rose found this "pretty disturbing", not so much because of prejudice but because one of her dining partners was prone to swearing, scowling and "mean" comments. The other woman was "sweet" but "not with us" and the first resident would talk disparagingly to her. Rose found this upsetting. The final

disillusionment of that first meal was the food itself, which Rose described as “dreadful.” She decided at that point that she would not be eating in the dining room very often.

5.4 Settling In

The entire experience of her first few days left Rose with a very vivid and negative impression. Yet, Rose was convinced that there was a better way to welcome new residents and help them feel comfortable. As she circulated around the building more and began settling in, she also she made observations about aspects of life in Forest Place that she could not reconcile with her values or her lifestyle. These observations, and her ideas for improvement, were a large part of our remaining interviews. When discussing these topics, she often used a voice I came to call ‘frustrated oversight’. In her position as an operator of an after school care program and as a high-level volunteer at her community centre, Rose had direct ability to influence the delivery of services. In Forest Place she continued to use her keen sense of observation for service improvement, but for almost a year she had little outlet to *do* anything with her ideas.

Initially, the one exception to her frustration was the opportunity to work with Forest Place on redeveloping their Resident Handbook. About five weeks after she moved in, Rose attended an inaugural meeting for AL residents only. The new Director of Resident Services wanted to create dialogue between this group and the management, and also to gather input from residents on how to improve the resident Handbook. Rose immediately volunteered for the project. She described to me in great detail the changes she made in her version of the Handbook, such as adding a thorough description of the neighbourhood amenities and transit. When she moved in, she said very few people could answer basic questions she had such where to find services or what bus routes to take. In describing her project to me, Rose carefully chose

her words to demonstrate the warm and courteous language with which she intended to write the section, restarting one sentence several times until she felt she captured the correct sentiment. At the time of our first interview, Rose had already spoken with the staff overseeing the project about how *their* language in the booklet was inappropriate or even inaccurate in places. For example, she requested they remove a line that said, "A pleasant dining experience awaits you." She clearly felt comfortable in her advisory role.

In addition, Rose proposed two actions that she felt would enhance the comfort and support of new residents. First, she suggested a change to the move in procedure, where a care worker would not only meet the new resident at the beginning of the move, but also invite him or her to call after getting settled. At this point, the care worker would come back with the Handbook, offer help if needed and be available to answer any questions. Whether this procedure was adopted is unknown. It would involve a procedural change so presumably it would require a somewhat formal process to be passed. However, it demonstrates Rose's intuition around what makes people feel cared for. Second, she initiated a "buddy system" where new residents are given the name and phone number of a Forest Place resident who has volunteered to show them to them around, help them find their table in the dining room, and answer questions. As Rose put it, "It's no good saying, welcome, welcome, welcome but you're going to have to make your own way and your own friends." This system actually was implemented over the course of our interviews – both Rose and another AL resident volunteered to be buddies. At the time of our final interview, her additions and suggestions for the Handbook had been submitted. The new cover photo had just been taken for the Handbook, and Rose was involved in designing this as well. She was not sure if all her edits would be accepted, but she was satisfied to have done her part.

But while Rose was positive about the new, friendlier Handbook, she remained dissatisfied with certain aspects of life in Forest Place. In particular, the poor quality of the food and the physical, social, and recreational environment were continued sources of frustration. Regarding the food, for example, Rose stopped eating the majority of her meals in the dining room "within ten days of moving in." Beyond her personal taste, Rose felt that a diet low in sugar, fats and refined or processed products was very important in managing her arthritis symptoms:

> The one thing that I can control myself is what I eat, which has got a lot of to do with what affects the arthritis. Eating good food and controlling what good blood cells I've got is the most important thing!

Rose was therefore unhappy with the food 'choices' offered to her at Forest Place, which appeared to be of a more stereotypical institutional variety – overcooked vegetables, instant potatoes, frozen foods, fried foods, menus based around meat, and minimal whole grains. Knowing that there could be ways of improving food quality, but that Forest Place was not pursuing them, seemed particularly frustrating for her. Drawing on her life experience, Rose observed:

> ...they can't even get the salad out without having the celery brown and curled and the broccoli, it's brown...All I know is, by the time I left [the before and after school care program] I had a hundred and twenty-five children between two schools...and I could give them carrots, celery sticks, cucumber, sliced apples, sliced oranges- and it was all looking as if it had just been [prepared]. Yes, there is a way.

Given the large emphasis on meal provision as a hospitality service in AL regulation and policy, I asked Rose if it was a requirement that she go to the dining room for meals (lunch and

supper). She responded, “They actually tell you that at the interview. It’s what you pay for. And you pay a lot.” Rose opted, instead, to go to meals from time to time, eat whatever seemed palatable or check with other residents if anything had improved, and excuse herself. The rest of the time she ate what she prepared in her suite’s kitchen and the food her family brought when visiting. I asked Rose what she would have done if she did not have a kitchen in her suite. She responded without hesitation that her children would bring her food. “And they’re quite prepared anytime; all I have to do is give them the word...And that would be that I can assure you.” In fact, her children offered to “go to the press” about the food quality, because they felt it was “terrible for everybody”, not just their mother. Rose clearly felt supported by this, but preferred to try to work with Forest Place to bring about change (as I will discuss below).

In addition to the quality of the food, Rose was disappointed with the dining atmosphere. To her, the absence of tablecloths, or even placemats, was a further demonstration of a lack of care. She described a haphazard system of centrepieces: “Sometimes, you may have a single flower in a bud vase; the next table won’t have anything, another table will have four or five going rotten.” She felt that, “if it looked nice before we even sat down...it would improve the socialization. No two people ever sit at a table and talk afterwards. Even when they’re really good friends.” There also appeared to be an implicit understanding that the dining room was functional – not social. Rose commented that “you would not be welcome” to gather in the dining room between meals, because immediately after one meal was cleared the room was set for the next meal. This practice is understandable between the two lunch seatings and two dinner seatings, but I observed staff setting tables for supper as I walked through at 2:45 one afternoon.

The other issue Rose had with dining atmosphere during her first months was that the seating arrangements appeared random and did not encourage social connections. And although

Rose had compassion for residents with dementia, she felt that some of the behavioural challenges that occurred during meals made dining more of an unpredictable undertaking than a comfortable, social experience. She observed, "Even if we all had one person like this [at our table]... It's fine. But at least two people have got to be able to talk and get to know each other." At our last interview, Rose was pleased to report that Forest Place management had begun offering AL residents meals as a separate group, which initially came about during a period of extensive plumbing renovations at Forest Place. Because the dining room was not accessible, management had begun serving meals using various arrangements, including AL residents in the library or TV room. Rose felt that this made a "better atmosphere" because "you're sitting with people either you relate to or you've been used to for x number of years." Rose even hoped that giving the AL residents a chance to get to know each other better at mealtime might lead to new, AL-specific activities or connections that previously were not offered in the broader Forest Place programming.

Rose's observations on atmosphere in Forest Place were not confined to dining. From her narrative it was clear that aesthetic was something personally important to her, and also that she implicitly understood the relationship between the physical environment and one's socio-emotional wellbeing. While her "gorgeous" suite with its beautiful view was arranged to her liking, she felt that Forest Place had "missed the boat somewhere" in terms of the common areas. This irritated her because she felt "it wouldn't even be that hard to fix." For example, she mentioned that some upholstered furniture was actually too deep for persons with mobility restrictions to get in and out of with ease; that there was an outdoor patio but no chairs; that there was a lack of intimate visiting areas in general; and that the type of tables and chairs in the lounge made it too difficult to visit.

> So you get these little groups. And that's fine, if there [were] sufficient chairs that were light enough to drag around and join the group. But there's not. And then the other unfortunate thing – and this is a common complaint that I have either overheard, or somebody has said it *to* me – they'll have somebody playing music...It is *so* loud. It is *so* loud... I'm deaf; I have hearing aids. But even if I took my hearing aids *off*, I couldn't stand the volume. (original emphasis)

Rose said she stopped going down to the afternoon tea because of these factors. In this way, the physical environment was a literal barrier to social engagement.

Rose's interest in creating a better physical environment for socializing was related to her discomfort with the lack of community and caring she initially felt at Forest Place. With dismay, she recalled incidents witnessed in her first few weeks there, where she felt that residents in real distress were left to cope on their own. In one example, a woman with cognitive impairment was upset and standing in the dining room/lounge area because she thought she was meant to be eating at that time. Rose asked if she was alright and then went to find a staff member. She imitated the indifferent tone of the staff member saying, "Tell her to sit over there and I'll deal with it." Rose said "that sort of thing shocks the heck out of me" but that it had happened "three times since, where I have found a person either standing and looking, or sitting and crying" and staff were not attending. That someone could *not* respond compassionately in the presence of such need was completely counter to Rose's values.

Rose also experienced a similar sort of self-involvement among residents. She felt at first that residents were startled or "suspicious" if she tried to initiate conversation. Yet here was an area where Rose could do something to make a change, just by acting as her genuine, caring self.

Rose decided to wage a campaign of friendliness - saying a simple hello to people she passed or gently approaching people who looked distressed.

> So I thought okay, there's only one way I'm going to handle this, and that is I would walk through and I wouldn't stop. I would simply say "Good morning!" and pass somebody. Or, I'd ...walk by and say "Hello!" and keep walking. And in the beginning they'd you know, [miming silent startled or shy reaction]. But now... I can walk through that dining room and ... I would say every person I say hello to turns 'round [and] smiles...All I'm doing is acknowledging the fact that they live where I do, and I'm happy I'm here, and happy they're there. And it doesn't mean to say that I am going to stop or I *need* to stop and converse... But then you do it often enough that they'll stop and do it anyway. (original emphasis)

Rose was then able to create even deeper connections with some residents, who shared their bad days and good news with her. In this way, she was able to replicate that sense of knowing and caring about a lot of people that she had in her independent living community.

But while Rose enjoyed making connections with other residents, she did not join the existing recreation activities offered by Forest Place because she felt that they were tailored toward the complex care residents rather than the AL residents.

> Because the care people, *need* so much care and they focus- and I'm not saying it's incorrectly- they focus on stimulating them as much as possible. So everything is geared [to them] - the bingo, the shuffleboard, the little exercises, the singsongs. (original emphasis)

She would have enjoyed taking an exercise class but found that the existing one, with its chair exercises and other gentle movement, was not vigorous enough for her needs. Having taught

yoga at the community centre, she was sure that there could have been a way to modify the activity to different levels: “I just know that they could do more than they are doing, and I just wish there was something I could do, too.” Instead, Rose took to daily walks as often as her arthritis would allow.

Inside her apartment, however, Rose said she was “perfectly happy” reading, playing Scrabble on her tablet, writing emails and chatting on the phone to friends and family, watching the cooking channel and also keeping her apartment clean. She had an agreement with the housekeeping staff that

> about every third Saturday I’ll let them come in and vacuum and wipe the floors. Other than that I do it myself, you know. It’s good for me. And I always say to them, there’ll be times when I can’t, and you’re going to have to do the lot. That means cleaning the bathroom and the kitchen and, you know?

As hoped, the move to Forest Place meant that Rose was able to see her family more. The visits were sometimes shorter, but they could be more frequent and spontaneous because she lived closer. “[I’ve] never gone a weekend without seeing one of them. And some weekends I see all three.” As well, she regularly saw friends from her former community who either came to visit her or whom she travelled back to see. Until her mobility worsened, she was returning via transit every two weeks to meet them, and when that became difficult they came to see her more often. She enjoyed showing them her new neighbourhood and going for coffee or dinner. She eventually arranged to have wireless internet installed in her suite so she could be in closer touch with the important people in her life without going down to access the internet in the lobby to take video calls or send emails. These supportive relationships must have been very important for Rose in the first few months, when she was struggling to find a way of integrating her need

for *doing* and *caring* with her new life at Forest Place. Accepting that she was 'just' a resident did not seem to occur to her. Her core values and her years of experience making people feel welcome and comfortable meant that, while she felt at home inside her suite, she was not satisfied by just shutting the door to her apartment and forgetting about all the rest.

At the time of our first interview, she mentioned that she had thought to join the Residents' Council, but after attending one meeting she felt that it was mainly "to do with the people on the other floor [Complex Care]." Rose enjoyed collaborating with the AL Manager to update the Handbook and set up the buddy system, but the involvement was limited in focus and duration. In our second interview, approximately six months after moving in, she was happy to share that she had begun volunteering at a local neighbourhood house. At one point I asked her what she would do if there were no neighborhood houses or community centres nearby; whether there were any opportunities like that within Forest Place. She responded after thinking for a few seconds: "No. Other than what I've created for myself as it is." Unfortunately, Rose had to stop volunteering after several months, because she was experiencing pain walking. Eventually it was discovered that her existing osteoporosis had resulted in a broken rib.

What she did not mention until the last interview was that, around the same time as she stopped volunteering, Rose had actually "asked to go and see" another AL facility just slightly farther away from her children, which had only been in the construction phase when she was looking for an AL (but would have been her preferred choice). What changed Rose's mind and helped her decide to stay at Forest Place was that she was finally given a chance to bring about real change within the residence via two organizational committees. She went to England at Christmastime, and found that when she came back, "all of a sudden there was a lot of work to do." While she was not willing to say categorically that she would never consider transferring

again, she said there would have to be a situation she “could not tolerate” in order to pursue it. About staying at Forest Place she said, “What I’ve gained is feeling...that I’ve still got things I can do... [This situation] just can’t go on, you know. It’s no good, complaining if I don’t offer a solution.”

The first committee she was asked to chair was a committee of AL residents’ dedicated to improving food quality. It formed at the same meeting where Rose agreed to rewrite the Handbook, but since then had only inconsistent success. The original chair suggested that Rose might be more effective in the position because she was well connected with staff and management. She agreed, saying that she would “do anything to make the food better.” At the time of our last interview, Rose was finding satisfaction at being able to talk to kitchen staff directly and then problem solve with Forest Place management. For example, Rose learned that the frozen vegetables were often cooked hours ahead of the meal at which they would be served and then reheated, resulting in an unpalatable effect. She also discovered that soups, a mainstay of the menus, had no written recipe and thus varied widely in quality from one meal, and one cook, to the next. Rose was able to talk to key staff who were willing to investigate these procedures and rectify them. What seemed to make Rose more successful than the previous Chair of the committee were the relationships she had already cultivated over her year at Forest Place, and also her sensitivity to using respectful language and collaboration during negotiations.

> ...I said [to the committee] I think we’ve got to change our approach. You cannot talk about what *you* want and what *you* like in this way. You *can* say, ‘That doesn’t seem to be a very popular item *because*, for instance, there are five people at my table and four of them didn’t eat it’. You know? (original emphasis)

The second committee Rose was asked to join was the Operations committee. This committee was comprised of various management and staff from Forest Place, and Rose was invited to represent AL residents. In this role, Rose was able to voice some of the observations made with her frustrated oversight, as well as lend her input to new endeavours undertaken by Forest Place. One example was developing a better system to recognize and celebrate staff. In an Operations meeting discussing the poor turnout of staff for their appreciation event, Rose astutely observed that the simple arrangement of seats was not reflective of a caring attitude from management:

> I said, "To begin with the, all the residents are here [gesturing room layout with hands]. Anyone that's coming forward is standing at the edge of the dining room area, and there's a semi-circle of [management]... And so they walk across and we're all sitting there... I said, "It should have been the other way round. She said, "What do you mean?" I said, "*They* should have been sitting up there and we should go to *them*. You know, *we* are appreciating you." So it's the wrong way round. (original emphasis)

Rose seemed very invigorated by her role on the Operations Committee – "It's really interesting and I *really* look forward to those meetings (original emphasis)." As well, Rose began to have one-on-one meetings with the AL Manager, simply to discuss and collaborate on organizational issues at length.

> I said...*nobody* is connecting. There isn't one person who walks around and doesn't do anything; simply *looks* at the situation and thinks, "That is actually is not right, what's going on there," or... "You know, that would be so much better if that was moved over here; it would mean that when they do their exercises people weren't stuck round behind the piano and couldn't see." And then they all have their areas of responsibility but there

> *has* to be, there has to be a coming together and that's what I'm *hoping* will come out of the Operations [Committee]... If there is a problem, in any department, it's everybody's concern, and you need to know about it. Even if *you* can't do anything about it, do you have a suggestion? You know?

As a result of her participation on these two committees and the avenue they provided for action, Rose finally began to feel a sense of purposefulness that sustained her in Forest Place. It seemed to be a familiar identity for her, working alongside staff and being involved in the machinery of an organization. This was especially important given that her arthritis made physical functioning more difficult and the option of travelling to external volunteering less realistic. In order to feel settled in AL, Rose clearly needed more than just 'five hospitality services and two personal support services'. In particular, Rose needed to be able to live according to her values of caring and doing. Having established a channel of communication between herself and the management at Forest Place, Rose continued to look forward to the improvements she could help make for the benefit of staff and residents alike. She was able to start making goals for personal projects there, such as teaching yoga once again. Her narrative incorporated a vision of herself in the future, and the possibility of creating meaningful change. Overall, it seemed like the final piece to her relocation story had moved into place:

> Mainly it's because, I guess, I feel I'm doing something and feeling useful. And I think that's the thing that affects most people. They come here and they feel useless, because, they don't, they don't even have to fill up their own kettle, you know what I mean?

Chapter 6: Ian: So What Are You Going to Do About It?

I was born [here] and so was my wife.
We were educated here,
Got married here,
Did everything here.
I never thought about the future without her.
But then, she got sick.
I felt, you know
She's my wife and I love her and I'd like to look after her.

I started to learn to cook.
I found I really enjoyed it.
I made a little cookbook for myself.
It was the most helpful thing in the world!

After a while we had to put her into a care home.
That's where she died.

Let me see -
Into a new apartment when my wife died.
I don't think I was there more than a week or two.
Then six or eight months in the hospital -
You did what you bloody well were told.
Then I moved into the first place;
I think it was assisted living.
Well, I don't know what the hell it was!
Too much supervision
not enough independence.

My children felt I was well enough to move to independent living.
They thought it was very nice.
(I guess it was very nice).
There were still a lot of rules,
A lot of expectations.
I guess I was there a year.
My son said, "Dad, you're running out of money! You gotta move!"
It was decided by my son and daughter
that the one with the least waitlist would be the better.
It was just a fait accompli.

The transition from there to here was easy.
I knew what to expect.
I was excited because it had a full kitchen.
But in the course of all those moves my children decided,
"Well he doesn't need this and he doesn't need that."
By the time I got here I had very few kitchen utensils.
I don't know *where* they put that book.

Slowly get this place organized,
Sort my clothes out.
I've got some pictures out, ready to hang.
It sounds like you could do all that in a couple of days
but I find that I run out of energy.
I think it's because of my age.
I don't know.

The only hardship I have -
You don't *find* anybody.
Most of the people I've bumped into here -
No personality, no spunk.
They're just lifeless.

I think there's one place I'd like to go, and that is Tofino.
I can remember many times at our cottage
[there'd be] a big westerly blowing.
We used to go and sit down
almost at the water's edge and watch the storms.
But then I thought about it.
I don't know I want to sit over there alone all day.
So I gave that up.

6.1 Introduction

Ian called me to set up an interview shortly after he found the research poster taped to the door of his Forest Place suite. I offered to meet with him to go over the consent form and explain the study before he committed to it, but he declined this step and was comfortable booking an interview for the next day. I emphasized his anonymity as a participant and he responded that he was not particularly "bothered about all that." When deciding on a location for the interview, Ian

was unexpectedly considerate of my status a parent and asked if we should meet somewhere more convenient for me than his suite. I assured him that it was not a problem for me to come to him, and so we agreed that I would meet him at Forest Place the next afternoon.

My impression of Ian from our telephone conversation was of a genial person. This was confirmed when I stepped out of the elevator on the ninth floor and he was there to greet me warmly and escort me to his suite. His studio apartment was bright, with hardwood floors, a view of the city and mountains, and a small but full kitchen including a standard-sized fridge and stove (a point of pride). His motorized scooter was parked in the bathroom. He pointed out the boxes he had yet to unpack since he moved in four months prior. The bed was not made and there was a pile of washed and folded laundry, possibly sheets, on a loveseat in the corner. His living area also contained two upholstered chairs, a desk with papers, and a television. He invited me to sit wherever I liked, and I chose the chair that did not look like it was his preferred seat. That one, which faced the television, had a small table next to it with a drink already on it and was surrounded by a few baskets and piles of paper.

Ian told his relocation narrative spontaneously, in the middle of signing consent forms and going over the other initial details to be covered by the university's ethical interview procedures. He began by saying "Well before you ask me questions let me tell you that...I moved in here about April the first." At this point he gave a several minute long version of the events leading to his move to Forest Place, ending with "So that's my story, that's how I got here." He went on to explain that

> Where this all started, I was about to say that, the moving is okay, but in the course of all those moves, my children decided "Well he doesn't need this and he doesn't need that " and so on and so forth, and so by the time I got here I had very few kitchen utensils... I

had *no*, drinking glasses, I had *no* cups and saucers for tea or coffee...I have one glass...I haven't got a teapot. And I haven't got a coffee maker...so, all I can offer you is cold water, cold beer... and a cold Coca-Cola. So, if you feel thirsty and you like one of those things – And I have one, one glass mug. Brand new that I just bought. (original emphasis)

There are several points stemming from this anecdote. The first is that I had actually heard Ian's relocation narrative before I fully realized that I was hearing it. For the rest of the interview I tried to draw out more details of the story, clarify timelines, and to get to know the characters. I met with Ian three more times in his apartment over the next three months, each time asking him to expand on this initial narrative and add more context from his life story.

This relates to the second point, which is that I found Ian to be wonderfully accommodating. As with his concern over offering me a drink, Ian wanted to make sure I had what I needed for the study. Before I arrived he said he spent time wondering what he could say that might be of interest, or if he was even a suitable participant. At the end of the first interview he said he had enjoyed talking and that I could call "seven days a week" for a follow up. In our final interview I asked him why he had wanted to participate and he said he remembered doing studies at UBC when he was a student and he knew how hard it was to get people to take part. I have no doubt that Ian would have agreed to a fifth or even sixth interview. Sadly, when I attempted to contact him several months later to clarify some information, I found his phone number to be disconnected. An internet search revealed that he had died just a few weeks after our last interview. As a result, I was unable to ask him about gaps or questions that arose during later analysis.

The third point arising from the mug anecdote is that it highlights one of the themes from Ian's relocation narrative, which is **diminution**. Diminution refers to both an action and a

process of "diminishing or making less" (Oxford English Dictionary; 2016; http://www.oed.com/view/Entry/52918?redirectedFrom= diminution#eid). It can also encompass the elements of "taking away; reduction; lessening; incompleteness" (Phelps & Lehman, 2005, p.428). Beginning with a turn in his wife's health and ending with missing kitchen equipment, Ian's journey to Forest Place was marked by a series of losses and changing circumstances over which he had little control. When the dust settled, Ian found himself to be living a different, and smaller, life than he had a few years before. Some of these losses were the result of normal life processes (i.e. loss of a spouse; a decline in health). Other losses resulted from actions taken by himself or others, such as the financial losses incurred by leaving work too soon or the loss of some possessions meant to be stored by his family. In some cases, Ian's voice and agency were taken away as family decisions, health care professionals, and AL regulations/environment restricted what he would have liked to do.

The theme of diminution is related to two other themes in Ian's narrative. The first is the anthropological concept of **liminality**. Grenier (2012) uses this concept in her work around transitions and older adults through the lifecourse and I found myself thinking of it when listening to Ian's interviews. Liminality speaks to the notion of 'being between' stages. Many of Ian's reflections and comments indicate that he was seeking a way to live meaningfully in his new circumstances, but felt hindered by his diminished social, financial, and professional resources. As such, he was 'stuck' in finding a way forward to the next phase of his life. One particular area where he could "see no solution" was his need for companionship. **Seeking connection** was therefore another theme within Ian's narrative. Ian was sociable by nature, so whether it was chatting with the housekeeping staff, trying to start a band with other residents, attempting to date, or simply wanting to discuss local politics with someone, he sought a remedy

to his loneliness and boredom through conversation and human interaction. I think part of the reason he enjoyed the interviews was because they helped fulfill that need to connect.

Below I will introduce Ian and present a summary of his relocation narrative. Within these sections I will highlight how his story is infused with the themes of diminution, seeking connection, and liminality.

6.2 About Ian

Ian was an 81year old Caucasian man with a sharp wit and ready laugh. Although he was very open as soon as we met, I learned about his life in a convoluted way over the course of the interviews. We would pick up wherever I began, without much spontaneous embellishing from Ian. As such, it took some time to build a deeper sense of his subjective experience of the events that led him to move to Forest Place. He admitted to "pondering" some of the interview questions between meetings, and the last the last time we met he said he felt I was "getting a better picture" of his experiences. Information about Ian's work or family typically came out in anecdotes related to questions or clarifications sought. He mentioned nothing about his family of origin, with the exception that he was born and educated in Vancouver and that, growing up, his family always "had a nice-sized house." I learned from his obituary that he was of Scottish descent and had one sister. The stories Ian did volunteer tended to be centered on his wife and their children (two sons and two daughters). Ian's wife was also from Vancouver and when they got married they moved to their first apartment, which Ian could actually see from his suite at Forest Place. They moved twice more before buying the house "where the family grew up and [the] children were raised."

> Our family was son, daughter, daughter, son. My eldest son lives here [an entrepreneur], my eldest daughter lives in New York. And she's ... in a banking company, and then my second eldest daughter is here [a real estate agent]. And ...our second eldest son is living in London, England, where he is married and has children and is also in the banking business.

Ian seemed to be supportive of his children's careers and to accept that the local son and daughter were sometimes too busy with work to visit:

> I said [to my daughter],"Have you got any time to come and see me?" "Well, I'm pretty busy, Dad." "Well, what's that mean?" "Well, I've got two listings...one is 11 and the other is eight million dollars. Each."...And I said, "So what's the future hold?" "Well, we're working on another listing of four million dollars." "Well", I said, "good for you!"

Perhaps this was because, as a lawyer, Ian had been in a very demanding profession himself. It was an identity he retained long after he had formally stopped working. In fact, two of the boxes in Ian's suite were files from one remaining client who still had questions from time to time. He appeared to have enjoyed his work, and although none of his children were "interested" in law, he was hopeful that one of his fifteen grandchildren would also choose law as a career.

Despite his busy work life, Ian seemed to have been devoted to his family and especially his wife. When I came back for the second interview, Ian had been able to get his son to hang the rest of his pictures, including a painting of their family home and a beautiful portrait of his wife that he commissioned one year when his law firm were having portraits done of old partners. Talking about not having a car anymore led him to amusingly reminisce about some hijinks with his children and their friends when, early in his practice, the family were using a taxi service instead of owning their own car. I got the impression that the family had eventually been

comfortable financially; they had a “large” family home, a collection of antiques, and an island cottage on the west coast – “a little hiding place.” Ian said he would take a two or three weeks’ vacation there, but would “ensconce” his wife and family for four to six weeks, “and she loved it!” She would also travel with him to the annual law conferences in Canada, and between these two activities, he said it fulfilled their need for travel.

At one point I asked Ian what he and his wife had planned to do for retirement and he replied,” I read some of these articles about planning for your old age or your retirement and so on. I don’t think we ever did.” What he thought that they would probably have done would be to go exploring British Columbia’s west coast on their boat.

> We had a boat, which you could sleep on. There’s picture of it right up there. And ... every time we went out on the boat it was like a second honeymoon. It was just the two of us and, our kitchen was probably not bigger than that [gestures to his kitchen], smaller than that, but we had a stove, and a sink, and a refrigerator. And [my wife] used to love [it] – “This is like when I was [first] married, I’m only cooking for two people!” She’d been used to cooking for six or seven! And so I guess, if we thought about it, we thought well, when I stop working we’ll go and cruise for half the year.

Their plans changed, however, after an incident on one of these boat trips. Usually when they docked, Ian’s wife would help by using a pole to prevent him from bumping into other boats. The last time they were out, however, “She goddamn near fell in the water one time when she tried to do it.” Ian realized that his wife’s Huntington’s disease had progressed and they would not be able to go out alone anymore: “That was it; we had to sell the boat! It was...a big change in our lifestyle.” So after ten years of being out on the boat most weekends, Ian sold it shortly after this incident. At the time, he said it felt like a “relief” because maintaining it was an

added “worry” when he was “only concerned about looking after [my wife].” He said he had only just recently begun to realize what selling the boat had meant to him.

From that point on, he said “you [couldn’t] ever say again that she was well.” Over the course of approximately ten years, her symptoms progressed from initial physical incoordination to incontinence and the inability to feed, dress, or otherwise care for herself. She also developed symptoms such as cognitive impairment and behavioural changes. I commented that it must have been a difficult for time for him, to which he responded that it was “not so difficult as it was *sad*...But I mean... here it was. What are you going to do about it? I think that’s the attitude” (original emphasis). Ian said he looked after her for about five years, although he could not quite remember.

> I felt you know, I don’t need any lady coming in here and bathing my wife and feeding my wife and cooking our meals. I can do that, and she’s my wife and I love her and we lived together and- I’d like to look after her. So, that was not a difficult decision.

While the progression of her disease changed the nature of their relationship and the intimacy they once shared, Ian seemed to gain in empathy and appreciation for his wife after experiencing what it is like to look after someone and to run a home: “The one thing I learned very positively...was to admire what you women do. What your life is like.” He was dedicated to learning to cook properly and found that he “really enjoyed it.” To help himself, he made “a little cookbook...Well, I mean I made a little memo, like when you’re studying a course, your notes. And I had *many* notes, all indexed...and it was the most helpful thing in the world!” (original emphasis)

What he had not considered when deciding to look after his wife, however, was how that would affect his ability to practice law.

> What I overlooked was, gradually I had to reduce the hours of practice until I had to virtually stop practice. You know, the firm was saying, "Well listen, we never see you around here, we know you're busy, we're happy with what you're doing, but it's not helping our firm." And so I had to resign from the firm. And then I went out on my own for awhile and then that didn't really work... There was too much of a commitment there that conflicted with my commitment at home.

Eventually, the family moved Ian's wife to a care facility. Ian continued to be a devoted caregiver however, and would often go once or twice a day to feed her because he felt the facility was not "all that great." About her death he said, "You're sad, you're disappointed. But it's inevitable. You can't do anything about it!"

After his wife died, Ian tried to take up his law practice again, this time from home. He said that "almost to the day" that he made that decision, two legal Acts that governed his area of specialization were massively revised. In thirty years of practice, he dealt only with those two Acts and he said knew them "backwards and forwards." When he went to look at the revisions, he found the Acts to be almost unrecognizable. In talking with his old colleagues over dinner, Ian realized that unless he was immersed in learning the changes daily, he would "not be able to keep up." He said he also realized that" I could be charged with negligence, because I didn't know the Act well enough to be able to give them that advice!" The two boxes of files in his suite were from a client he was still able to represent, because his questions were not related to the Acts. However, he said that this was "petering out, too." I estimate that Ian would have been in his early to mid-seventies when the Acts were revised; I would have liked to have talked more with him about what it was like to find himself out of work at that age without ever having decided to retire.

Soon after he realized he would not be able to practice law again, Ian moved out of the apartment that he had shared with his wife (they had already moved from their house after their children left), into a smaller place in a neighbourhood closer to his children. In a few short years, he had lost his lifestyle, his career, his life's companion, and the remains of the home he had built with his wife. As I will discuss in the following section, these losses were quickly followed by the loss of his health and his ability to live independently. Ian was therefore faced with diminution across many aspects of his lifestyle and sense of identity. Understandably, he said that the previous several years of his life were a phase he'd "like to forget."

6.3 Moving in (and in, and in)

As mentioned, Ian wondered if he was "right" for the study because he had not gone straight from home to AL. Rather, he moved through hospital, AL, and Independent Living settings until arriving at Forest Place specifically.

> I thought I'd mention it because I thought, I didn't *have* an adjustment coming *here* [to Forest Place]... The adjustment was when my wife died and I was alone. That's the *big* adjustment. And then moving to my first apartment, where ... my children would come in to see me but not very often, or not more often than was needed... So *that* was an adjustment... And then when I went in the hospital I didn't *have* an adjustment, I mean, you're just sick and you're going in the hospital and they look after you...
> (original emphasis)

I assured him that every story was unique and valid. In fact, his story helped me to realize that I had been making assumptions about how older adults move through the system of care – simply progressing from home to facility to facility, receiving greater increments of care until living out

their lives in one setting or another. Another valuable aspect of Ian's story that I tried to convey to him was his ability to speak to different settings and make some comparisons. Although he felt he was "acclimatized" to institutional life by the time he arrived at Forest Place, there were still particular characteristics, such as the in-suite kitchen, as well new developments in his life at the time, which did affect how he experienced the move.

Ian initially said that he was "perfectly happy" to move to the smaller apartment after his wife died, but he said later

> I didn't like it because it was different. And I didn't have the comfort of going someplace in the apartment where I like to sit and a chair that I like to sit in and watch TV or something, like I did in the other place... I'd not got used to anything...It was still a foreign place to me.

I asked him if he was involved in downsizing his furniture and possessions in preparation for the move, and he said," I certainly felt I was making the decisions, because I agreed with how everything was being sent." After having an appraiser in to assess the value of the household goods, he and his children made lists of which items would go to what child and arranged for shipping. Some items were stored at his children's' homes, and anything else he "hadn't any use for" he got rid of. Despite feeling like he was overseeing the process, Ian still found that things he wanted or was looking for were not in his new apartment.

> And there was a certain amount of stuff that...wasn't there. So I'd ask my son or daughter, where was it? They didn't know where it was. And [they] said, "You've probably given it away, Dad." I said, "Goddamn it! I haven't given it away. I have it. I just saw it." And so, they root around in their own homes where they'd stored my stuff and find it. But yeah, it was a period of upheaval.

There were other losses that Ian experienced during the transition to the new apartment, all within a period of a few weeks. It was the first time that he had been without a car in many years, and he also realized that he now needed to use a walker. On their own, these changes in a person's lifestyle and independence would take time to adjust to; in combination with everything else Ian was grappling with they may have made a difficult period more challenging. In addition, Ian estimated he lived that apartment only three weeks before his son came to visit one day and noticed a wound on his heel. He said his son called the public health nurse, who "took one look at it, picked up the phone and booked me into the General." Ian was diagnosed with pressure wounds and subsequently spent the next six months in hospital.

Having worked in a hospital setting with older adults, I knew that these types of wounds occur when people are sitting or lying down too long and circulation is cut off to the pressure points. I wondered if perhaps Ian had been experiencing some depression around this time, leading him to be more sedentary. It would certainly be understandable given the turmoil he was experiencing. He might also have been more sedentary due to his restricted mobility. He said he did not remember sitting more than usual, however. I asked Ian if he had noticed any changes in his health before the nurse was called, but he said he just felt "tired all the time."

Regardless of the cause, Ian's condition was serious: "I damn near died in the hospital, that's what the kids tell me." His son who lived in England was contacted and came to visit, although Ian said no one told him how serious his condition was and he did not stop to think why his son and the grandson he had never met were visiting. He says he wished that someone would have told him that he was "pretty sick" and explained why it was important that he do certain things like finish his meals: "I think if I knew I was really sick and I really *needed* it, that I would have sort of force fed myself" (original emphasis). The whole chapter of Ian's hospital stay is

marked by the diminution of his independence and control, which he never fully regained. From that point, he was caught up in the machinery of the elder care system where doctors, case workers and his children decided where he could live. I asked him at one point if he felt he had choices during the different moves he made after the hospital, and after a long pause he said

> No. No. Certainly not. There, there was a feeling of, inevitability, to each move I had to make. There was a feeling of, you know, this is the lot that you find yourself in and you'd better do it. You'd better make the most of it…Nothing in my mind would be choices.

Ian never returned to his apartment. His children decided to give up the lease shortly after he was admitted to hospital. He said that he was not sure how that was decided, but he did not seem to mind. He assumed that it was because his prognosis was poor and because he had not fully settled in, so it made sense for his children to simply move him out and store his furniture. Instead, he was discharged to a private pay facility that had multiple levels of care. He believes he was admitted at an AL designation. He said that, at the time, there was no discussion of him living on his own again because he was still recuperating from being bedridden. He remembers being coached by the physiotherapist at the hospital to avoid using his cane when he went for the interview, to show he could "get around." In the facility he had a private room with his own bathroom and he went to the dining room for meals. After the isolation of the hospital, he enjoyed meeting other residents. Although he felt the setting was relatively free compared to the hospital where "you did what you bloody well were told", he still felt there was "too much supervision...and not enough independence." I asked for an example and he said:

> "Well, this is the time you're going to have your breakfast." And I said, "Well, I don't feel like breakfast." "Well, you're going to have breakfast – that's the rules!" And that

made me feel badly; I was telling them I wasn't going to do what I was told, and they were telling me that I had to.

In the facility, the choice over something as simple as when to eat breakfast had been taken away. It also seemed that his care plan had been negotiated *for* him, rather than *with* him. Specifically, Ian was told "you've got to have a bath every morning" even though he was "not used to having a bath every morning." In a very candid anecdote, Ian told me about the experience:

> Well, you know, they'd whistle in, "Hi Mr. __. Time for a bath." I said, "Oh God" to myself. "Well, I guess you want to take all my clothes off and get in the bathtub, right?" "Yep!" In we go to the bathroom and they'd help me take off my clothes and there I was standing naked in front of a *girl*, who was younger than my daughters. And in the shower and they'd wash me and then help me dry. Every day... I must say eventually you just didn't *care*... If you told me, ten years ago, that I was going to get undressed and stand naked in front of a wo- a *girl* – and they were *girls* – that was my daughter's age, I'd say "You're bloody crazy!" But anyway...that's what you had to do... And so that's what I did. (original emphasis)

Happily for Ian, his children decided after six months that he was "well enough to move up" to what he understood to be Independent Living. Ian astutely observed that "there's a very fine difference it seems to me, between assisted and independent." From the information he provided, it appears that he was moved to a private pay facility similar to Property A from which I ordered an information package. He did not have a full kitchen in his suite, and he went to the dining room for meals. But he said they "hoped", rather than required, residents eat there. Staff came in once a week and took his sheets to launder them. He did not have pill management or

bathing assistance, but could have had them "for a charge." He found it to be a better place to live than the AL, but he says there were still a lot of rules as to what he could or could not do. As a man who had been interested in politics all his life, he was pleased that there were at least a few residents there who were "with it" who would talk about "things that were going on in the building." He sat in on a Residents' Council meeting at one point to bring up some ideas, but quickly decided that it was not an authentic mechanism for change. "Really it was... the management is sitting here, give us your ideas you council people, tell us what you don't like, what you do like, and we'll take this back and decide whether we want to do anything about it or not." He realized that there were echelons of decision-making that were not under the control of the management in the room, so he saw little point in attending future meetings.

After living at that residence for about a year, Ian said "that was about when the cost thing sort of loomed its ugly head." Because he had stopped contributing to his RRSPs when he left the law firm to care for his wife, he was not able to sustain the payments to the private facility. As he said, "it was a bit of a rude awakening when my son said we're going to have to look at finances because they're going down." It was decided by his children, whom Ian said he trusted because of their business experience, that he should move to a publicly subsidized facility. So Ian faced another set of losses: the loss of his residence, the loss of the financial freedom to choose where he would live, and the further diminishment of his voice in the process.

The realm of publicly subsidized facilities was new to Ian and his family. He said his "son or daughter made the inquiry as to how we... got into one of these places." After having gone to look at several, his daughter commented to him:

> There's not really much to choose from; they're all the same size, basically, they have the same amenities and so on; not much to *choose*. It's location, you know... I don't know

> whether you'd like the people this place or that place but you're stuck wherever you go, you know, you can't choose the people. (original emphasis)

The unknown factor of what it would really be like to live in one of these properties bothered Ian, who had the first-hand experience his children lacked. His family would report on the places they had seen and their impressions, but Ian says he mostly stayed out of the discussion. I asked him why, and he responded

> I mean, how can you make a decision from pictures?...Who are the *people* there? You know, what are they like? And so, it's not so much I didn't want to be a part of the discussion. I just couldn't see any *point* in it. Because I wasn't going to be able to make a decision based on description anyway. Nor was I going to make a decision on some nice pictures...You've got to be there for a month and know whether you like it or not. (original emphasis)

At the same time, Ian was undergoing a series of assessments required for AL. He commented, "An awful lot of people wanted to know what my problems were." He found it frustrating to be asked what he wanted when he could not realistically have it. He reflected, "A lot of questions...I couldn't *answer*. I mean if I'd said, "Well look, I have an income of [a] hundred thousand a year, and this is what I want", I could have told 'em!" He met with one particular professional three or four times. He was not sure of her position or title, but he supposed she was a "junior psychologist." At one point, he says he told her he was lonely and that the only place to see people was to go to a restaurant up the street. He suggested they go, but he got a clear 'No way, José! Against all rules.' I said fine, but that's my problem and you can't solve it!"

Once Ian found out that there were suites with full kitchens, however, he refused to consider any other type of suite. He said that knowing "there was a kitchen where I could cook my meals...that had a real attraction." There was a newly built, private facility that had some subsidized AL suites with full kitchens that Ian thought "would be great", but there was a three or four year waitlist and his son told him "we can't wait that long." I asked if there was ever a discussion of him going on the waitlist for that AL while he lived somewhere cheaper in the meantime, but Ian said no. He said his children's position was, "Well, look, we've done the work. We found a place. Let's get on with it. Or just leave it and redo it a year from now."

The place they had found was Forest Place, and Ian recalled that it was approximately a three month wait before his name came up. He was surprised that it took that long to "free up some space." When he went for the final interview and tour, he was not impressed. "If there hadn't been a kitchen there...I would have said *take me off that list*!" (original emphasis). I asked him to elaborate, and he said after meeting with the "bigwigs" they were to go up and see the suite:

> Well we came through the main dining room area, which is also the reading room and the dining room and exercise room, everything. And you know, half the chairs were full of people who obviously didn't know who they were or where they were. And it wasn't the most exciting *view*, to me. (original emphasis)

His son and daughter were not particularly sympathetic to his reaction, and in fact gave him some misinformation. He said they told him he would have to "lump it" because in a government subsidized building "they can't have one building for just assisted living; they've got to have the whole spectrum." Despite looking around at different properties, they did not recognize that Forest Place was one of only a few campuses of care in the city. They also

appeared to emphasize how much worse it could be: “They told me about one place that a friend of mine was moved into, over near (Street), and it sounded like a horror story to me.” Ian’s reflections on eventually accepting Forest Place were ambivalent. On the one hand, he said he was satisfied that his son and daughter’s business experience qualified them to research and choose the best available options, but on the other hand, his own observations about the atmosphere and potential of Forest Place were not very positive. In the end, however, he felt that the decision was already a “fait accompli”, so he sublimated his voice to those of his children.

Ian and I had talked a bit about all the moves he had made in his life and how he actually had “a pleasant memory of them.” He and his wife used the same moving company for all their moves, and he felt that they had a good relationship. While the movers were carefully packing all their belongings, the family would spend some time together and go for lunch. By the time they were done, the movers would be at the new house unpacking. He said it “really was a piece of cake!” In addition there was no time constraint – “If we got it done today, fine. If we didn’t get it done until tomorrow, that would be fine.”

Moving to Forest Place, however, was “the most difficult” in his recollection. In part, this was due to the time constraint of having to be out of his old place “before noon” and into his new place “after, but not before noon.” They also had to arrange to get the key when they drove up to Forest Place. Ian felt this process was further complicated by the fact that the “kids didn’t have the right equipment.” Instead of renting a truck, Ian’s son used the one from his work, which could not fit all of Ian’s belongings in one trip. It appeared that the helpers (Ian’s son and daughter and two of their friends) also did not take care to pack the boxes “in any particular order”, so Ian found all manner of items thrown together haphazardly:

> [They] basically just went through the place and filled one box and then filled another box. And ... they came to half a box full of books...Well, then they put *clothes* in or put some other damn thing in with them, or shoes. And nothing was marked. I really couldn't ask them, you know, do that. And so I got here and I didn't know where anything was. The bed was made. My pajamas were on the bed. I carried in my own bottle of booze, which I certainly needed [laugh] when I came in here! Oh, God! I think they put everything in that closet and left this one, so that everything was jammed up together and it, you know, just moving *clothes* is a tiring thing. Oh, yeah, [laughs]...this, this last one was a bad one. (original emphasis)

Ian could not specifically recall where he was during the moving process, but he thinks he went out to dinner the night before while they packed, and lunch the next day while they unpacked. He was certainly not in control of his move to Forest Place, or even very involved in it.

6.4 Settling in

Perhaps because Ian was "acclimatized" to living in AL and IL environments, he said he was "comfortable" when arriving at Forest Place. Upon further reflection, Ian supposed that he felt "curiosity about how things happened" in the new setting, rather than anxiety or trepidation. For the first few days he said he was in his room, but he "was told" how to go down the elevator to the dining room for lunch and dinner, and he knew the door codes if he wanted to go out. Although he had lived in the neighbourhood many years ago, the changes in the interim meant that none of it was very familiar. Yet, he seemed confident about going exploring in the neighbourhood to find the services he needed; he likened it to going to law conferences in a new city and needing to purchase some items he forgot. Although he was disappointed with the

financial circumstances that required him to move to Forest Place, he was looking forward to cooking and to the new neighbourhood amenities.

Ian was genuinely happy to have a kitchen again and it was a constant topic in our interviews. As discussed above, it was literally the reason he agreed to accept Forest Place. When talking about cooking and his kitchen, Ian used an abundance of positive words: “pleased or excited at the prospect of cooking”; “I quite enjoyed it”; “so happy to get back to cooking.” When I asked him if Forest Place felt like home, he said it did, “particularly with the kitchen.” Apart from feeling that “cooking...gives a certain amount of independence,” it seemed like Ian was also interested in cooking because he sought a project or hobby. At one point he said, “I don’t think I have any mental stimulation right now. I think that’s one of the reasons I like cooking, is you have to think about what you’re doing.”

But it was not a straightforward process for Ian to stock his kitchen and begin to use it. The night he moved in, Ian said he had a sense of “pleasant anticipation” at the prospect of cooking, but it was “coupled with worry” because he was not sure if he was even allowed to use the kitchen. Apparently, during the intake interview at Forest Place, Ian made a casual remark about being excited about cooking again. In response, a staff member who Ian thought was his case manager made a negative remark that he paraphrased in two interviews: “Well if you don't want to come down to meals, there's a lot of people out there on the streets we'd like to feed instead of you.” After moving in he tried to clarify the policy with the AL manager “in a roundabout way” so as not to accidentally implicate himself, and he said she “didn’t give me any encouragement, that’s for damn sure.” His son and daughter were not sure either; his son suggested he “adhere to those rules absolutely, keep your nose clean, and be the perfect little tenant for six months, and then try and see if you can bend the rules.” Perhaps the ambiguity

around the use of the kitchen is why, four months after moving in, Ian had only just purchased a second mug. The other setback Ian experienced with cooking was that his prized notebook was missing and none of his children or grandchildren (to whom most of his kitchen items had been given when Ian was in the hospital) knew where it was. Ian said the loss "annoyed the hell out of me." His enthusiasm around getting back to cooking was therefore diminished somewhat from the outset.

Ian went ahead and used the kitchen, despite the minimal equipment and the worry "niggling at the back of [his] mind" that he would be "booted out." In our first interview he spoke about trying to find out what his "report card" in Forest Place was, and he said:

> I wonder when someone's going to phone me up and say "Ian, you haven't been into the dining room for two months! Now what's going on? And if you don't want to come to the dining room well then we'll have to give you notice to leave." That's what my worry is.

Ian explained that he had initially gone down to the dining room for his meals, but stopped after two months when he was able to collect some dishes and begin buying groceries. Food service or quality did not seem to be the main reason for this. He liked the fact that, in the dining room, food was brought to the table by trolleys instead of having residents line up cafeteria-style, and he said the food choice was "reasonable." Instead, it seemed that Ian was discouraged by the social atmosphere. He said there was nothing that would "urge" him to "go eat or to stay late" after a meal. He said he was "tired" of always being the one who had to make conversation. This comment linked to Ian's general dissatisfaction around social connections at Forest Place. In the previous residences where Ian had lived, he said that he could go in the common areas "and quite easily strike up an interesting conversation with two or three

people...And in fact if you went in there and there [was] a person there and you didn't say anything, they would engage you in conversation." At Forest Place, however, Ian found "quite the opposite" in that others would not initiate or encourage conversation. He imitated himself in an elevator with someone to demonstrate: "How long have you been here?" "Oh I don't know, too long." Ian found a lack of vitality in the social exchanges he attempted – he characterized the people as "lifeless" and not up to date on current events that could fuel a conversation. This was frustrating for Ian, a gregarious person who was very interested in politics and world affairs. Ian found some opportunity to talk about these things with the housekeeping staff; in one case he said he invited the young woman on shift to watch a news clip with him about something going on in her home country and she shared with him some details that were not in the segment.

I found one story Ian told about seeking connections particularly touching. He says he found out that one of his dinner partners played the spoons. A week later he says a woman came to entertain and she played "the songs that everybody used to sing" on the piano. Ian played ukulele so he suggested to the fellow, "Why don't we get together with this gal and pick some pieces that we could practice and play, you know, like *Five Foot Two* and *You are My Sunshine*...?" But, the man was not interested. Ian still seemed exasperated when he reflected, "I never got to first base." In this anecdote, I could sense Ian's brightness and enthusiasm that were just waiting for an outlet. Unfortunately, he did not get a chance to realize this goal and he ended his story by saying

> I mean, I haven't talked to people about this but I have the feeling that, they get here...and they sort of view it as the end of the road. And, there's no future look forward to; they're here until they kind of go out in a pine box!

Despite the lack of social connection, Ian said, "quite frankly I like this better than the other places because of the kitchen." His response to the lack of social opportunities was therefore to retreat to his suite and his own pursuits. Where Rose seemed to be able to expand into the space of Forest Place over time, Ian seemed to take up less. When he took me on the tour of Forest Place, it appeared to be the first time in six months of living there that he had really explored some of the common areas. He admitted he had only just been up to see the penthouse sitting room for the first time the previous week. He was able to list activities he saw advertised in the residence, such as church services, bingo, "singsongs", and daily "calisthenics", yet he did not participate in them. Instead, he said he followed current events, watched sports on television, cooked, and went out into the neighbourhood on his scooter. He was having such trouble with his balance and leg strength a few weeks after moving to Forest Place that he "persuaded" his children that "I really needed that thing or I said I'd be just locked in here, I can't go anyplace." Having the scooter enabled him to grocery shop, meet his children at restaurants, get to medical appointments and, importantly, experience some socializing. In fact, the only two perks of moving to Forest Place that Ian could mention were the kitchen and the "lively" retail and entertainment street in the neighbourhood. He seemed to find it sustaining to be able to go into shops and restaurants even if he had nothing to buy: "Any time of the day or night it's full of *people*. And by and large most of them are quite *friendly*" (original emphasis). Ian said this resource made "life *unbelievably* more pleasant, than if I didn't have that" (original emphasis). Knowing he had his own suite with a kitchen waiting for him upon his return was also satisfying: "When I'm outside and going around and seeing all these shops and restaurants and people I've no thought: 'Oh God, I got to back to that hole in the wall.' I quite enjoy it!"

But as our interviews progressed, I began to get the sense that Ian was not completely happy in his new location in life. Insofar as he was not able to rectify some of his recent losses, Ian seemed to be in a state of liminality where he found it difficult to make plans or imagine the future. At one point I began a line of inquiry by summarizing that Ian had been through what he called a "period of upheaval" but now that he was at Forest Place he presumably would not have to move again *because of his financial situation*. But I neglected to state the last part of my thought, and Ian responded with, "Yeah, I'm here to die...That's what you wanted to say, but thought better of it." I was caught off guard by his direct response, but I rephrased my question to ask if he had any plans, now that he was settled into a place. He flatly stated, "No." He looked down to the box of legal files, paused for several seconds and, tapping his hands on the chair, said that he did not get work from that one client anymore. He then told me the story about the revision of the legal Acts that he used in his practice. He concluded with the reflection that "that part of my life is *gone*" (original emphasis). He said that he knew he could ask a junior lawyer for help to "get up to speed", but that "that part doesn't, doesn't really turn me on, too much. I guess I'm getting too *old*, that's the problem" (original emphasis). This admission was followed by a thoughtful silence.

Ian acknowledged that he was experiencing some other changes in his abilities and interests, such as feeling "bushed" after tidying his apartment for a short while, or not finding usual activities, such as bridge, appealing. But there seemed to be a distinction between changes due to the ageing process (i.e. energy levels, physical function) and changes related to diminished circumstances. He said, "I'm certainly more conscious of my age, and the limitations it imposes. But not because I'm living here with older people. It's because there's [sic] things I want to do, and I can't do them!" He pointed out that his dissatisfaction was more related to

having “no friends... no girlfriends... no hobby...and no money.” I asked him how he “got his head around it” and he responded emphatically: “I try and forget about it! I don’t know how you wrap your head around it.”

For example, the lack of a “girlfriend” or “mate” had become more apparent to him since moving to AL. For a while, he was meeting younger women through friends of friends, but that his children were quite negative about it.

> I would ...tell my children that I met this good looking girl. The first question, always: “How old?” Well, [they] might as well find that out. I tell them, “Thirty, thirty-five, well, thirty-five, forty, forty-five.” “God, Dad. She’s younger than I am!” When I’d come out with them, my two daughters [would say], “Get rid of her! Stop that! That’s crazy!” And they, I mean, they’d *really*, jump on me. And so what the hell, I did. (original emphasis)

So while Ian had found some opportunity to build new relationships, his chance to explore them were diminished by family members who strongly discouraged him from pursuing them.

In other cases, Ian’s previously unsuccessful attempts to generate social connections at Forest Place worked to maintain his diminished social circle – they had left him skeptical about pursuing more. As mentioned in the previous chapter, Forest Place undertook some major plumbing work during the time that I was conducting interviews with Rose and Ian and they were offering the AL residents the chance to eat together as a group in a smaller room. Ian showed me the poster for this invitation and reflected that perhaps he would “try it out for a month...I don’t know.” When I noted that he seemed hesitant, he responded:

> If I could find someone to talk to...All this floor is full of women...You say hello and they may mumble hello...But they don’t say anything...So I am not really anticipating finding

> some[one]. I'm not looking for a woman that is so interesting that I would like to spend lots of time with her. [I] would [just] like to find someone who knows what's going on; who reads the newspaper. But I'm not hoping for that. I'm just, "What the hell."

With his frustrated attempts to connect with the other residents in Forest Place, and his children's disapproval of the women he had met, Ian could not reconcile his desire for companionship. He said "I see no solution to that, whatsoever." His loneliness was compounded by the fact that one of his closest friends had died recently, and the other one had terminal cancer. He said his grandchildren visited, but not as often as he would have thought. I got the sense that his children would come to help him if he asked, as he did when hanging pictures, but that visiting with them was not necessarily a regular part of his week.

Ian was also unsettled by his financial situation. He obviously knew he had moved to Forest Place because of a reduced income, but in our final interview he said he had recently come to realize that he was "broke." He said it was "disconcerting, because I don't have a lot of places where I want to spend money." The few things he did wish he could do were now out of reach. He said he would love to get a boat, but it was "financially out of the question." We briefly discussed his interest in travelling to Tofino, "the one place" he had always wanted to go, but the combination of a lack of finances and the lack of a travelling companion meant that Ian "gave that up."

The combination of his poor finances, forced retirement, and lack of companionship left Ian feeling that he had "nothing to do." He seemed to value productive activities; he commented once that he did not particularly enjoy movies because "if you finish your dinner, you turn on a movie, and the next you thing you know it's eleven o'clock. And you have accomplished nothing." He was even bothered by not being able to do all the chores he wanted in a day: "When

I get certain things done I just say, “Oh Christ that’s enough for today!” And I think to myself after I sit down, “Well what did you do? You didn’t *do* a damn thing.” He did mention that he had attended one of Forest Place’s AL-only resident meetings and he indicated that it was something he would be interested in attending again. This could have been the positive social connection he had been looking for, but Ian passed away before more meetings were held. Similarly, I had found a brochure for a local community centre with older adult programming and I shared it with him. He immediately skimmed it and found that they offered a legal clinic for seniors. He became quite upbeat thinking about volunteering there and about seeing the completed community centre, which was being built when he and his wife moored their boat in the area. Given more time, it is possible that Ian would have been able to find new activities and relationships to sustain him. As it was, he was not entirely settled in his new life six months after moving in. I observed this in a literal sense during our final interview, on a tour of Forest Place guided by Ian.

6.5 Forest Place: The Tour

When I set up the last interview with Ian over the telephone, I asked him if he would be comfortable taking me on a short tour of the building. I was sensitive to the possibility that he would not want to be seen with me, a researcher, and have to explain my presence to curious individuals. However, Ian was very willing to show me around; he said he spent time before my arrival thinking about what I might like to see. He also asked me if it were alright if he used his motorized scooter on our rounds, as though it might interfere somehow with my agenda.

After we finished our last interview session, we made preparations for the tour. I left my recorder in his apartment because I did not want to capture any conversations from residents who had not consented to participate and I did not want us to look conspicuous. I went into the hall to

wait as Ian got on his scooter. He asked if I had been to the penthouse. I had not, because although Rose talked about it in her interviews, she had never wanted to meet me at Forest Place. Ian had only just been up there for the first time a week prior, when he attended his first AL residents meeting. So, our tour began by riding up the elevator to the penthouse. Walking into the room, one of the first things I noticed was the panoramic view of the city, and the spectacular effect of the early autumn leaves of gold against a blue sky. Some trapped fog led Ian to reminisce about the view from his old office in the neighbourhood, and how he would be able to see the fog roll in from the bay to the harbour. This was the only spontaneous narrative sparked by the tour. He was quite animated and smiled recalling it – similar to one interview when he told me about storm watching on one of the West Coast Islands with his family.

The penthouse was large and bright, with an entire wall of windows and patios on either side that were open for use. I did note, however, that anyone in a wheelchair or using a walker would have to somehow get over the high frame of the sliding door. There was a bookshelf piled with paperbacks for a free lending library, and a magnifying machine for reading. One plant had a sign that it was not to be watered since it was being looked after by the woman in a suite on the floor (there were three or four Independent Living suites on the penthouse floor). There was a separate kitchen off one side of the main room, and more of a tea/coffee kitchenette on the other side. There was a comfortable-looking sitting area on either side of the room, each with plants, and wooden-framed upholstered furniture. It looked inviting, but I recalled Rose saying that she never came up to the penthouse to read because the furniture was simply too deep for her to get in and out of. I was somewhat surprised to see that the centre of the room was dominated by a boardroom-style table and chairs, because I had assumed the room would be for residents only. Ian made no comment about it, however, and seemed pleased by the penthouse. He mentioned

that if he wanted to have a dinner party for his family he could book it. When we looked on the room schedule, it appeared that families do book the room for functions, but I noted that they must book around various facility board meetings, health care staff training, and other health care/housing organizations. There was a movie night listed, and I wondered how many people attended. I wondered in general if having to share the room with administrative functions subconsciously influenced the level of ownership residents felt toward the space, in terms of being able to use it spontaneously and consistently.

After the penthouse, Ian and I rode the elevator down to the main floor or Forest Place. We got out in the corridor of the AL/Independent Living entrance to the building. At the one end of that corridor were the AL entrance doors with their swipe-card or key-code exit, a waiting area with chairs, the hairdresser's shop, and a locked room. We turned in the opposite direction and came upon another short corridor that led to a series of rooms. I found it very revealing that Ian had never been down that corridor. It felt a bit as though we were trespassing, despite rooms that were obviously meant for recreational programs. One room was a community kitchen and one was an art studio, both of which appeared have been taken over for other purposes during the plumbing-related construction work in the building. There were also recreation worker offices and a large room that was the Forest Place chapel. The chapel's lights were partially dimmed and at the back there were four or five people in wheelchairs watching a video on the Yellowstone Geysers. Some standing individuals who looked like staff were talking, and looked up when we peered in. The arrangement of the room made it look very much like an afterthought to be showing videos there – the spectators and empty chairs were crammed in around the screen behind the pews and among other pieces of equipment. Ian pointed out other mounted monitors

for me in various places; he said they were informational. The one I saw by the hairdresser's shop and AL entrance/waiting area was displaying proper earthquake procedures.

We went back out to the AL/Independent Living corridor and continued down it another few feet, into the main room of Forest Place. It was a large room, which served as the dining room, lounge, waiting area, and exercise area. The kitchen along the far wall had been shut down for the pipe refitting, and there was a temporary wooden divider with plastic sheeting to cut off what was left of the dining area from the construction zone. The table numbers were on plain, un-laminated paper, sticking up like antennae from a wire holder in the middle of the table. In my field notes I recorded that they "looked sad and lopsided and dirty". Earlier, when I had arrived for my interview with Ian it was the 1 pm lunch seating and I noted the unappetizing "food" smell that I remembered from working in long term care. Perhaps this was because the kitchen was closed and the food was being catered by the nearest hospital. The smell was gone by the time we were having our tour, and staff were setting the tables for the dinner service, several hours away.

There was an attempt to delineate some zones around the remaining empty space of the main area with groupings of furniture, such as a microphone stand and a TV monitor on one wall between the lounge and the dining room. Ian said that was where entertainers performed. Along one wall of the lounge, institutional-type reclining chairs were lined up facing the empty centre area. Ian said that the exercise classes took place there, but he did not attend. A few people sat in the chairs and I noted that it would be hard to have a conversation without turning one's neck awkwardly or dragging one heavy chair to face the other. I also saw the tiny "Parisian" tables and iron chairs that Rose had mentioned were awkward for visiting. As well, there were several small coffee tables with two chairs each, but they seemed to be 'floating' in the empty space and

offered little privacy. The coziest seating areas were located in a few nooks with partial walls and the area beside a second, complex care entryway where people seemed to be waiting for cabs, rides or visitors. These spots had upholstered chairs and couches, and coffee tables.

Off to one side the lounge, there were three or four birds in a large cage that I noted were making shrill noises. Ian said they were new. I noticed a tuck shop counter that was closed at the time. I asked Ian about the covered patio adjacent to the dining room but he said it never got sun and that he had never seen anyone out there. There was also another room, which Ian said he thought might be the library. There was no one in it. The round tables had bright plastic tablecloths over them and heavy wooden chairs around them. There was a set of brown, bound encyclopedias and a few other books. An older model computer monitor and keyboard were on a table by the window.

In general, there was not much activity, except the few residents seated in little pockets around the edge of the large space, and the staff moving through it. There were people lined up sitting, sleeping, and in a few cases, talking in the chairs along the back wall opposite the defunct kitchen. I remember thinking that there would probably be more activity on a weekday, but then I realized that it *was* a weekday. I asked Ian what he thought on the day he moved in and he gave his idiosyncratic chuckle and said "Well just look around at what you see. Not too many people jumping around in here."

Ian asked me if I wanted to see where the "big shots" were, so we crossed the main room to a corridor on the other side. We walked over the threshold and remained by the main reception desk, not going farther back to the administration offices in the warren. There was an unspoken hesitation between us to intrude further into this area. He said floors above were the "more complete" care section. It has its own elevator. I could understand then why Ian had specifically

told me to come in the entry by the AL side of the building and not the second entry in the main room; I could have confused elevators and ended up on a long term care floor. Perhaps he also did not want me to be confronted with an initial impression that I was in a 'nursing home'; most of the people in the common area appeared to be residents of the complex care floors. I noticed the daily activities and menu posted close to the entrance to the complex care wing.

At this point we turned to go back to Ian's apartment. The tour had been brief but it seemed as though we had seen all there was to see. We had not met any staff or residents whom Ian greeted or seemed to know. I asked Ian questions along the way but he did not have much to offer in response; I got the impression that he was really investigating and looking at the space for the first time. Yet there was nothing compelling us to linger. I felt conspicuous as the few individuals along the wall in the lounge watched us silently. At one point, a male worker in a white uniform seemed to be making a slow loop around and behind us. I wondered if he was trying to assess our actions or if he was simply making a routine walk through.

When we returned to Ian's apartment to collect my bag, I got the impression that he would have liked me to stay longer. At the start, I had mentioned that this would be the last interview and he seemed surprised. Now the moment had come to say goodbye and I felt sad and awkward about it. I tried to convey my genuine appreciation for all his help and sharing, and I tried to lessen the finality of the moment by mentioning that I might still need to clarify details with him later. As always, he offered to be of whatever help he could. Comically, I had to return to Ian's apartment because I did not know the key code to exit the building and Ian did not remember. He tried two numbers before finding someone who could give the code; I then exited out into the October sunshine.

When I met him, it seemed that Ian was still processing and integrating the changes that had happened in his life in the past few years. Physically, his possessions had come to rest at Forest Place and he seemed to have some amenities, such as the kitchen and a lively neighbourhood, to satisfy him. Mentally and emotionally, however, he was still seeking connections that could have helped to counter some of the losses he had experienced and to begin a new chapter of his life. It is unfortunate that Ian passed away before he discovered what that could be.

Chapter 7: Findings: Bringing the Stories Together

Rose and Ian's relocation narratives give detailed, contextual accounts of some of the experiences and complexities for older adults who move to AL. In this chapter, I incorporate the relocation narratives of all four participants to address two areas of analysis. In the first part of the chapter, I bring together the narrative of AL presented in the document analysis chapter and the narratives of participants. Specifically, I examine three major thematic areas (care and service plans, food and dining, and social/recreational opportunities) to find points of convergence and divergence. My findings indicate that, although basic services were being met, there was varying success in meeting the residents' expectations or core AL values such as choice, privacy, individuality, and independence.

I would like to include a note about the format of the first part of the chapter. For each of the topics of analysis, I include figures as a way to illustrate the polyphony of voices surrounding official AL policies and practices. The design of these figures is adapted from the work of Diane Rodgers (2009) who found that employing the dialogical format of the Talmud (Jewish religious text) enabled her to transcend the conventions of traditional qualitative research presentation. In the Talmud, codified Oral Law, as well as an ancient interpretation of that Law, are set in the middle of the page. Surrounding these are the commentaries of later rabbis. "The format allows multiple meanings and interpretations to coexist, creating a sense of dialogue between rabbis of many generations and the reader" (Rodgers, 2009, p.262). I found this layout very helpful when faced with many comments that directly related to AL policies. By presenting a passage from an official AL document and surrounding it with relevant quotations from participants, I was able to succinctly display residents' own voices while demonstrating any contradictions, similarities, or unique perspectives on the policies. As well, it allowed me to highlight different aspects for

expanded consideration and discussion. Similar to Rodgers, I used different fonts as a way of visually represent different voices. In recognition of the viewpoint of narrative theory that stories are always incomplete, shifting, and shaped by the particular contexts of their telling, I include a blank text box in each figure to represent alternate versions of participants' accounts – ones that might yet be told, or retold in a different way. In recognition of my involvement as part of the context in which these stories are told and the personal responses I felt when hearing them, I also include reflections from my memos that speak to the theme of each figure.

In the second part of this chapter, I focus on the larger accounts of the participants to examine their narrative structures and also discuss the interplay of personal stories with larger discourses of AL and ageing. Although participant observations, discontents and satisfactions shared similarities, individual responses to relocation and settling into AL varied. Social location, pre-existing personal narratives, and individual characteristics played a part in how participants storied their experiences. Concepts from narrative research with older adults, such as 'resilience' and 'narrative foreclosure', were useful in exploring how elements such as power and agency can be traced in individual accounts.

7.1 Linking participant narratives to AL discourses and policies

7.1.1 Care and Service Plans

Although the participants would have preferred to stay in their own homes, they recognized that by moving to AL, they would have access to particular services that could provide a measure of security or assistance. Ian, for example, was discharged to AL in order to finish his recovery from a long stay in hospital. At the time, he was not in a position to think about cooking for himself or maintaining a household. Although Rose felt she had stabilized

after a very debilitating bout with rheumatoid arthritis, she elected to go forward with her move to AL because she realized that the disease was unpredictable and she did not want to burden her children with coming to check on her. Moving to AL meant that she could have help when she needed, see her children more often and continue independently with the rest of her life. Helen, a 91 year old widow, made the move for her own peace of mind – after a serious hemorrhage from diverticulitis resulted in a hospital stay, she felt more secure moving to AL with its 24-hour emergency response. Mabel, another widow and the oldest of my participants (95), had a slightly different reason for moving. In recent years she found the upkeep of her home and shopping for groceries had become too much:

> I just felt that I wanted a little more, I'd had to do everything for myself there. And I just thought I didn't want full help. I thought oh, having someone make my meals is not too bad. That was the hardest part you know, shopping, getting your meals, getting enough for your meals.

According to AL regulations, care plans are made with each new resident before she or he moves in. These care plans are meant to ground residents' expectations, set the terms of service, and provide a baseline of function to ensure that residents' care needs do not exceed maximum AL levels. From a regulatory standpoint, this helps to maintain the distinction between AL and long term care. In my interviews, care plans in themselves were not talked about spontaneously, but participants described aspects of theirs as part of their overall narratives. To encourage more detail, I asked participants if they had a plan around what services they would receive before they moved in, or what services they currently received. It is noteworthy that participants tended to view their housekeeping services as part of this 'plan', even though this is a universal hospitality service that is not strictly part of the number of prescribed personal care

hours per week. From their responses, participants appeared to be satisfied with the flexibility and execution of housekeeping and personal care services that they gained from the move. Figure 7.1 is a summary of some of the comments participant had about their services.

Rose

All I wanted when I moved in was assistance with bathing... But I have written that *I* will ask for help when I need it. And I *don't* want it written in that Rose has to be bathed every day at ten o'clock.

And because *I* self-administer, I don't have a nurse coming in three times a day to give me medication. And that's why I was so adamant. I had to get a letter from my old doctor ... to say, "Rose...is perfectly capable."

Most times I will do all the cleaning. Because I do a little bit each day! Even if the hands are bad, all you've got to do is a little bit each day... I have, for the last 3 weeks since this has been bad, I've let them wash the floors for me.

Helen

In your first interview they'll tell you what services you can expect and, and what you will have to, what extra services, what it'll cost you. Apparently there's a – um, you can ask for a tub bath. The bathrooms just have shower stalls. You can ask; they have a community tub. And you can ask, you know, and they'll assign you a day but they have to- they won't let you do it on your own. They insist that there be somebody with you.

Information about assisted living for seniors* (OALR, p. 10, n.d.*)

Each resident needs to know the specific kinds of hospitality and personal assistance services they will be receiving. Staff must develop a plan with the resident when the resident first moves in. This plan will describe the services to be provided, the specific personal assistance services the resident will receive and how any of the services are being adapted for the resident's particular needs. The plan should be updated regularly and as the resident's needs change.

***Forest Place Handbook* (p.14)**

Personal routines and preferences will be respected and programs will be flexible. The tenant's sense of dignity and self esteem will be upheld during all encounters to provide personal care services...

Ian

A girl comes in and strips my bed, and takes any towels, and actually a little more laundry...I can give them my underwear and so on, a shirt, like this shirt, as long as it doesn't need any ironing. And she takes it away and then comes back and, dusts, and then mops, and makes the bed. And I have my own pain pill management. I haven't had a problem with forgetting my drugs and so, I'm assisted to the minimum.

Mabel

M: (Speaking to the cleaner who enters to take out garbage) She's here so I can tell her what a good place this is! And what a nice staff there is!
Cleaner: Awww! Well you make it easy, Mabel, when we hear from people like you!
M: Guess I didn't have too much junk today.
Cleaner: No, not at all! I'll just do the bathroom one and I'll be out of your way.

Jasmyne

Memo interview 1, Rose: Rose seemed to think that she had to make her own bed and couldn't get family to do it. Was she just using this as an example of families not being allowed to help? Because a) how would the staff know who made the bed and b) Ian's narrative indicates that they just make his and no fuss. In enforcing limits to level of care, who keeps track? How do residents know how much they are entitled to?

Figure 7-1 Care and service plans

The comments reflect different experiences of the AL care and service plans. Helen's quote frames her experience as less collaborative and more contractual – "they'll tell you what services you can expect." She found some aspects of moving to AL to be "regimented." We had to schedule our interview around her Wednesday time slot for using the laundry room, for example. Her comment about the bath is interesting because, even though Helen did not need assistance with showering, she was still not permitted to take a bath alone. Rather than give up her privacy, Helen chose to take showers in her own suite.

Rose's comments about her services show a similar conviction around what she would accept, but also some flexibility on the part of Forest Place. For her, being able to do her own cleaning was important not only to fully use and maintain her physical function as long as possible, but also because, as she told me, "I enjoy keeping my apartment clean." As discussed by Rockwell (2010) and Seipke (2008), the lifelong routine of housework can be an important part of retaining a sense of self for older women. She initially did all her own cleaning, until one of the workers eventually told her, "You must let us in sometime to do something, sometime." She eventually agreed to let them in every third Saturday to "vacuum and wipe the floors." I wondered if perhaps the comment was delivered as some sort of ultimatum for her to remain in Forest Place, but Rose said no, "They were smiling." Nonetheless, this comment reflects the power that staff have to subtly (or not so subtly) draw on the discourse of the regulatory AL texts and bring resident action in line with the expectations laid out there. During the arthritis flare up that she talks about in Figure 7.1, however, it seems that the help was genuinely needed and not conceded. Rose was also able to ask for aid with showering as required. She did have to advocate strongly for the right to self-medicate, possibly because one of her medications was a daily injection. In her opinion, it was simply easier for the pharmacy and Forest Place to arrange her

medication in the same way as the majority. A less assertive person may have given in to organizational pressure to accept medication management, but Rose was able to achieve a balance of independence and assistance in line with the assurances in Forest Place's *Handbook*. Managing her own medication also increased her sense of privacy, one of the founding AL values, because she did not have staff coming in "three times a day" to administer it. By extension, her observation indicates that for those residents who do not self-administer, the legitimacy accorded to the biomedical discourse and the regulatory texts might override resident privacy in the name of providing medical care.

An interesting aside, however, is that as confident as Rose was about negotiating her services and care plan, she was still unsure about how it aligned with the regulations on maximum care hours. Rose mentioned in our third interview that just two days prior she had her first interaction with the Forest Place case worker (seven months after moving in) because the worker needed Rose's yearly income tax assessment to check her monthly rate. There was no other exchange or inquiry about how she was managing during that phone call. I asked Rose if she had ever had another assessment for the level of services she received and if she could have an increase if needed. Rose commented in a playfully ominous tone: "Oh, I don't know, to what extent, do I? I don't know how much assistance I can get before I'm shipped. Downward [to the complex care floors]." Even though there is a heavy emphasis in AL documents around not exceeding care levels, Rose did not have a clear sense of what that limit was. This relates to my comment in Figure 7.1, about who keeps track of how much help one person receives and through what mechanism residents are kept informed about how much they are using in relation to the service limits.

Ian's comments about his housekeeping and personal care services give an indication of his minimalist interpretation of what he was entitled to. Unlike Rose, it did not seem to occur to him that he had a say in how his "schedule", as he called it, might be modified or that he might have the right to take on some of it himself. It is true that his ability to carry out any cleaning was likely limited by his trouble balancing or standing for any length of time, and he may not have attached much importance to doing his own housework. Cooking was very important to him, as I have discussed, but twice when I visited I noticed a strong smell of urine in the suite, as if from soiled clothes or incontinence product garbage. One time there was several whiskey bottles piled high in an already full recycling bin. At the time, I was concerned that perhaps Ian was drinking too much or not taking care of himself and that no one noticed. Wanting to know more about what staff actually did in terms of cleaning his apartment or monitoring his mental or physical state, I casually asked what would happen if he found that he needed the garbage or recycling to be taken out partway during the week. He said there was a number he could call, and someone would come to take it away. However, he said he did not like to "bother" the staff because there was "a ton of other people around" that needed more assistance than him. In one sense, Ian's right to privacy and independence were being respected. But it does raise questions around whose responsibility it is to help residents who may be having a difficult time adjusting, or how issues noticed by one tier of worker would get relayed to management.

Perhaps, though, Ian just did not notice any smell and was satisfied with the weekly cleaning. Perhaps the cleaners themselves did not take note – Ian described the cleaning as: "They whistle in here like you wouldn't hardly see them. And they're gone." Another interpretation could be related to the confusion Ian had around fees for service. Having moved

between private AL and private independent living before accessing publically subsidized AL, Ian was sure that if he asked for more services a week he would be charged. As he understood it:

> I'd be charged for the time of somebody coming up here every morning and getting me up and getting me dressed. Because certainly the showering, if I needed anybody, I was going to be charged that... If you can live alone and don't need help and don't bother them I don't think there's any cost charged. But if you're bothering them, or if they have to come and see you once a day for pills, or once a day to get you up, or once a week, to give you a bath or help you with a shower, that's all established...And I'm pretty sure that's charged for.

Strictly speaking, there is a cost for those services, but they are covered in the monthly AL rate. As I clarified in a phone call with the Manager of AL at Forest Place, residents are entitled to a certain number of personal care minutes per day, so as long as he did not go over that amount he would not (could not) be charged. I believe Ian was conflating the method of payment at his private AL and independent living residences, where one does pay per each additional service. At one point, Ian said that part of his "assistance" in Forest Place was the financial assistance he was receiving via public subsidy. It is telling that Ian had been there for six months and still did not know what was meant by a poster he showed me that advertised an "Assisted Living Residents" meeting. He said, "Now, I don't know what that is. I intend to find out, because "assisted", that they use here, I'm not sure if that's the same assisted living I thought it was." Ian's narrative illustrates the ambiguous place AL can have in the continuum from independent living to long term/complex care, and the assumptions that case managers might have over how much residents really understand about how the services work.

Finally, Mabel's comments about her care plan at the bottom of Figure 7.1 were similar to Helen and Rose's in terms of being flexible around what tasks she did for herself. But what I wanted to highlight with this exchange between her and the cleaning woman was the sense of warmth I felt pass between them. This is important because care plans and services are mandated by policy, but they are carried out at the level of one-on-one interactions. Mabel had only good things to say about her AL's management and staff – at one point she was talking about how the manager did not act like a typical manager and asked me rhetorically, "How many managers give you a hug?!" Rose's open dialogue with her care workers, Helen's praise of the care she was receiving, and Ian's description of inviting staff to watch news highlights with him similarly demonstrate that part of good care is caring relationships. It is as if the relationships with staff themselves represented 'care' itself. So while aspects of the care plans may have been at times rigid and at times ambiguous, participants generally felt positive about the level of input they had into them and the services they received as a result.

So far the discussion has focused on care plans, but at this point I would like to speak to a slightly broader notion of 'care' from a health and safety perspective as well as provide an example about other allowable service costs. Although both of the following are from Rose's narrative, they are important in illuminating how individuals entering AL become part of a regulated environment, and how the bureaucracy of that environment can constrain personal autonomy. First, in our initial interview Rose described how, shortly after she moved in, the fire department requested that management lock the doors to the stairwells so that in case of fire, there would not be residents unaccounted for if they fell and could not get out. At the time, Rose and others were using the stairs for exercise. However, organizational risk of litigation or accountability outweighed individual choice and potential risk. From the perspective of AL

regulation, this was a demonstration of diligent 'care', in that operators are required to keep a "watchful eye" on residents for the safety of all (*Assisted Living Registrar's Registrant Handbook*, 2011, section 2.2). As a concession, residents could apply for a key, but this extra obstacle made Rose decide it was not worth the trouble. Although she later said she "had gotten over that", she admitted it was a big frustration when it happened because she said, "I felt they were taking my freedom away!" This example shows how dominant institutional discourses, in this case, of health and safety, can serve to silence and overpower alternate courses of action or even discussion.

Second, Rose also was also quite upset that eight months after she moved in, her land line telephone bill had increased, leaving her with even less income for the month. She attempted to solve the matter by talking to the telephone company, who informed her that she could not negotiate a contract for her own suite because it was actually Forest Place as a whole who was the client. She had not even wanted a land line in the first place, but it was required by Forest Place. As mentioned in the document analysis, this example reflects the criticism around the lack of maximum rates for "allowable costs" as set out in the *Home and Community Care Policy Manual* (2012-2106). Both of these examples highlight how, in the process of moving to access a certain level of health care, individuals may end up making concessions around aspects of their autonomy, choice and independence.

7.1.2 Food and dining

A major expectation of AL is that residents will take lunch and supper in the dining room. Residents are told before moving in that:

> Assisted living is for people that need personal care as well as the hospitality services such as meals and social programming. If you don't require this or choose not to

> participate then you may be required to move out of your subsidized unit. (*Subsidized assisted living handbook*, Vancouver Coastal Health, 2012, p. 18)

Some residents, like Mabel, accept meals as a service they are gaining because they are ready to give up the work of shopping for and preparing food. Other residents, like Rose, Ian, and Helen, still enjoy cooking but are not encouraged to continue, either through a lack of a kitchen facilities or the inability to opt out of the meal plan. Being able to choose what, how, and when one eats is a lifelong expression of individuality and autonomy for many people, and relinquishing this kind of involvement and control over food can be a difficult process. In contrast to the utilitarian policy statement on nutrition from the OALR in Figure 7.2 below, the participant quotes show that there are a number of subjective and personal factors that contribute to a "pleasant dining experience."

As outlined in the quotes from Rose, Ian and Mabel, dining partners are a large part of whether mealtimes are enjoyable. Content in her AL as Mabel was, even she found that certain personalities could dominate the mealtime rituals, such as the resident who wanted the whole table to say grace. I did not have an opportunity to observe this when I had lunch with her; the field notes quoted in Figure 7.2 describe a very quiet lunch. It is true that we were sitting at our own table because I was her guest, but I also did not hear much conversation at other tables. This could have been due to the fact that many residents were on an outing, and also due to my presence as a stranger. Helen said she "lucked out" with her dining partners: "four women, two of whom are retired teachers. So you know it's quite a good group." In her case, communal dining did create social opportunity because the women from her table invited her to join their nightly Scrabble group. An important distinction between Forest Place and the ALs where Mabel and Helen resided, however, is that at Forest Place residents from AL and long term care floors

ate together. As mentioned, Rose found this to be a “dreadful shock” during her first visit to the dining room. While she accepted that residents with cognitive impairments were part of Forest Place and even enjoyed chatting with one such “dear little lady” at her table, she still found it difficult to spend her mealtimes negotiating the behavioural outbursts or emotional distress of her dining partners. At times she wished that staff would enforce basic standards so that agitated or belligerent diners would not disturb others. As shown in his quote in Figure 7.2, Ian found trying to make conversation with his dining partners frustrating enough that he eventually gave up and began to eat in his room.

Rose

There's no balance to the meal. There's certainly no nutrition...for this last week it's been: ground beef and maccaroni, or mac and cheese... and then it's been pasta, perogies... those chicken things again, chicken sticks, and then there was fish. All fried...Well, it astounds me.

I mean we've gone to them, in the very beginning and said: Look, we don't want to pay you for the food; we'll buy our own food. "Well you can't." They can't just take X amount off, otherwise we'd all have done that immediately.

They don't *think* about who they're putting you with. So I had *nobody* who I could talk to.

Helen

I do miss cooking. But I'm selective in what I eat and I don't make a fuss about my diet. I eat what I can on the plate...We had a tenant's meeting...and I made the suggestion that I would like to see more vegetables on the plate. Especially iron-rich ones like broccoli and kale and things like that. So, for awhile we were getting two vegetables and kale was included a lot. Or, broccoli was included a good deal. And a lot of that [was thrown]out! I saw the plates. So now they only serve it once in awhile.

Assisted Living Registrar: Registrant Handbook. Assisted Living: Seniors. (OALR, 2011, section 10.2)

Operators...must offer a menu plan that provides a rotation of balanced and nutritious meals.

Forest Place Handbook (p.12)

A pleasant dining experience...will be offered in our dining room...The meal plan will support independence through offering choices...The dining experience allows residents the opportunity for rich social interactions.

Mabel

The meals are good here; I wouldn't say a hundred percent, but they're pretty good.

Then we have one man sits at the table with us... he's actually quite religious which is okay, but you have to kind of be a little–He's a really nice guy but he always asks blessings at all our meals. I mean, I don't need to; I know I'm thankful for everything.

Jasmyne

Field notes from lunch with Mabel: Lunch was an interesting experience. I can see a bit of what Rose was talking about. Not a lot of conversation going on. A number of residents were on an outing. I was Mabel's guest so she and I sat by ourselves. I kept making conversation with Mabel but I think we were the only ones. She would sometimes lower her voice, even if it was a positive comment, so as not to...be overheard?

Ian

Oh God, when my children told me, "You'll have your own kitchen" I said, "You mean a kitchen I can use? For myself?" I couldn't believe my ears! And so when I came in here and saw the place and saw that it was a fully operational kitchen ... I was just delighted because I like cooking; I like to cook for my*self*! It gives you a certain amount of independence!

The first month I was here...I went to have my meals ... down in the dining room. And at my table there were three guys. And one was clearly out of it. And the other two seemed to know what was going on, but I tried to raise a discussion and it was impossible.

Figure 7-2 Food and dining

Without spending a large amount of time matching personalities of constantly changing residents, clearly there ought to be some consideration as to how residents come together for dining. Perhaps open seating is one option, so that naturalistic groups could form and support the 'social interactions' that are part of the mandate of AL. Rose was much happier to come to meals when Forest Place began offering the AL residents their own dining area; people were allowed to sit where they liked and build conversations based on mutual experiences. Even though she continued to eat little of the food, she enjoyed having tea or coffee and being social. Other touches as suggested by Rose, such as ensuring tables are set with attention to aesthetics, could improve the overall atmosphere and make it feel less institutional.

The other factor in mealtime satisfaction is, obviously, the food itself. Understandably, it is a difficult task to serve large amounts of food to people with a wide range of tastes and preferences. While Ian found the food at Forest Place "okay", Rose found it (negatively) "unbelievable." Helen and Rose had a similar desire to see more vegetables on the menu, specifically as a way to manage health concerns. Although the AL policy is to serve "balanced and nutritious meals", both women felt this objective was not being met according to their own standards. For a short while, Helen's suggestion at a Tenants' meeting resulted in more broccoli and kale on the menu, but they were not popular with other residents and so the trend did not last. Fortunately, Helen found that her AL had a variety of fruit and snack foods available so she could supplement her meals.

> They're very good, there's always a big bowl of fruit available and they have muffins and little bags of potato chips which I, incidentally, don't eat. I don't *like* them! And tea and coffee available, and bread and toaster [in the lounge]...butter available, jam available, you can make your toast if you want and a lot of people go down in the evening and do

> that. And they'll have a muffin, or... But there's always fruit available. *Lots* of fruit available, so that's a good thing. (original emphasis)

So while she was not able to make lasting change to the menu, Helen found that she had some acceptable options at other times of the day.

Rose had a similar experience at Forest Place, where the initial food committee was able to improve food quality for only a short while. When Rose took over as head of the committee nearly a year later, it took her several months of relationship-building and kitchen-sleuthing to discover where the problems lay in the chain of food preparation. She also created a system for resident feedback:

> What I do is I go to the kitchen chap, and he gives me four weeks' menus...He gives me a copy, I go and get four more copies done and then I give one to each of my committee members, right? And we all mark down on each day, morning and evening what was good, what they thought was awful, what they thought was awful about it, and then on the back they write for me what they thought the solution would be to that.

Not every resident would have the energy or interest to undertake such a task, but Rose was determined that improvement was possible. Importantly, Forest Place was a willing partner in this project, providing Rose with the legitimacy and support needed to be successful.

Regardless of the quality or palatability of the food offered, however, there seems to be an irreconcilable issue in terms of meal choice. Mabel, for example, was generally pleased with the quality of the food, but when I ate lunch with her as her guest in the dining room she expressed wistfully that she wished our dessert for the occasion was a little more decadent than a cup of canned peaches. She was my hostess, but she was not able to provide me with the type of lunch she would have chosen herself. This was a modest level of dissatisfaction; other

participants had more fundamental opposition to meal choices that were rooted in personal interpretations of healthy or appealing foods. The Assisted *Living Registrar Registrant Handbook* (2011) indicates that it is *up to the operators* to "agree to accommodate residents' special dietary needs (special or therapeutic diets, food allergies or intolerances, and/or special needs associated with chewing and swallowing)" (Section 4, p.10). If operators do so, the residents' diets must have a supervised dietary plan that is part of their overall personal services plan. The emphasis here is on medically legitimated diets – the resident has a medical reason to not eat what the AL typically provides. The power to define nutrition thus rests with medical experts, not with individuals themselves. Framed in this way, food preferences such as vegetarian, vegan, gluten-free (by choice, not allergy), halal, kosher, and other ethnic or cultural preferences would not have to be accommodated. Forest Place itself does not; their *Handbook* clearly states, "We regret that we are unable to accommodate special restricted diets however the daily menu offers a variety of selections" (p.12). I asked Rose about the "variety of selections" and she responded:

> Let's say an evening meal. Say they had pasta on a Monday, and Tuesday was going to be fish burgers. It's fish burgers or pasta from the night before. So it's warmed over food. At lunch time, like yesterday, it was soup. And then a chicken croissant. Now if you don't want that, then you can have a sandwich.

I asked Rose what kind of sandwich; she told me "egg or cheese." Her response led me to reflect on the predicament of those who consistently did not want or could not eat the main meal choices; what if they found that alternative menu items were also not good 'choices'? I wondered as well about the many multicultural seniors in Vancouver AL facilities and whether they were able to regularly eat familiar and preferred foods.

Rose and Ian, however, had another option available to them that many residents in AL do not: they chose to prepare their own food in their suites' fully equipped kitchens. Partly this was in response to the food and dining atmosphere, but also, Ian and Rose *enjoyed* cooking for themselves. Ian's relocation narrative and his quote from Figure 7.2 show that having the ability to cook was very important to him. Given the opportunity, he was happy to take charge of his own nutrition. One interview he excitedly told me of his discovery that the large supermarket in his neighbourhood had a selection of ready to eat kale, spinach, and even shredded carrot – " I'm supposed to eat [them] to make sure I get the right vitamins and so on. I thought, my God, I mean, take this home and make a salad or whatever! So they have everything down there, it's unbelievable what they have!..It's a goldmine of things." It was one of the few times Ian became so positively animated about a topic.

Rose said she enjoyed making soup most of all, but she also prepared other simple, healthy foods:

> What I do...is I will make a batch of vegetable chili. And I'll freeze them. In...little containers, you know? I usually, once a week, buy a barbecued chicken. Because that's sandwiches or supper. And I always use the bones for the base to my soup. And if I don't feel like cooking, it's usually because I don't feel like eating too much. So then if you've got a can of salmon and some good bread and some tomatoes and some cucumber that's all you need.

I once asked her if she would miss cooking, even if the food in the dining room was good. She replied, "It would have to be very good. You know your own taste buds."

Given that Ian and Rose enjoyed cooking and found that it helped to counter the more institutional offerings in the dining room, it is not clear why ALs do not consistently offer full

kitchens. As Rose understood it, the AL suites in Forest Place (originally built in 1980) were once independent living suites and thus, had kitchens. Mabel and Helen's AL facilities were built more recently and only had refrigerators and microwaves. Yet, I had one recruitment interview with a potential participant in her eight-year-old, purpose-built AL and she also had a full kitchen. It seems counterintuitive to build ALs that are meant to support independence but either cannot facilitate cooking (through lack of appliances), or will not facilitate it (through forced compliance with a meal plan). At first glance it might seem that operators are simply reducing 'risk' by removing ovens, but this logic does not follow since AL currently does not house people whose judgement or memory might put them at risk when using kitchen equipment. One could also argue that there is still a degree of risk in using small appliances such as kettles and microwaves, and these are allowed in the kitchenette-type suites.

In the case of Forest Place, having kitchens but being strongly encouraged to eat in the dining room created a contradiction of expectations. As discussed in Ian's narrative, the negative response he received about cooking from a staff member during his final interview left a lingering uncertainty as to whether he would be reprimanded for using his kitchen. Rose was quite open about her cooking, however, and did not attempt to hide it from Forest Place staff: "It's like I'm supposed to eat in the dining room. But they're not throwing me out because I'm not." Her quote in Figure 7.2 also indicates that there had been a discussion between AL residents and management over opting out of the meal plan. The residents were not allowed to opt out however, because the fee structure is meant to be inclusive of all rental, hospitality, and personal assistance costs. It seems a fundamental (and ageist) presumption of AL policy and regulation that older adults cannot or do not want to prepare meals. This is the case for a segment of residents, such as Mabel, but for others, moving to AL could mean a premature termination of

an enjoyable expression of independence and selfhood. Although it is unlikely that meal plans will ever become optional in AL under the current regulations and funding structures, building suites with full kitchens and openly allowing residents to use them would at least be an imperfect solution for those who feel that their dietary preferences or desire to cook are otherwise not met in AL. Imperfect, because it would place the responsibility and financial burden of improving food choices or nutrition onto the residents themselves, many of whom do not have surplus income after paying for monthly AL fees, prescription medication, and other bills.

7.1.3 Social and recreational opportunities

A third area of discrepancy between the discourse of AL and the experiences of participants was that of social and recreational opportunities. As shown in Figure7.3 below, providing social and recreational programs is part of the mandate for AL operators, and they are considered "a benefit" to individuals who relocate. AL operators seem to include communal dining as one way of fulfilling this mandate, as seen in the previous quote from the Forest Place Handbook in Figure 7.2, which states that "the dining experience allows residents the opportunity for rich social interactions." Helen was lucky, because out of her seating arrangement she was able to connect with a group of Scrabble players. The narratives of Rose and Ian, however, show that "opportunity" does not always translate into successful results. As mentioned in Chapter 5, when Rose was working on updating the resident handbook she actually suggested that passage be removed because, as she said, "It's simply not true!" Reflecting on why there is such an emphasis on mandated shared dining and assigned seating in AL, I suggest that perhaps it is rooted in the prevalent construction of older adults as lonely, malnourished, or isolated. This may be the case for some individuals, but not for the participants in this study.

Rose

Everything is geared to the people with much more severe difficulty. All the entertainment, all the exercise, you know. And it's very short sighted...I'm *hoping*...if sufficient people say they want to eat together, that maybe through *that*, we can then go onto things like leisure activities.

See they do play bingo and they do play all these games...But the independent people are independent, you know? They do go out.

Mabel

They have bingo, which I don't like.

Helen

The social life. It's almost non-existent.

Assisted Living Registrar: Registrant Handbook. Assisted Living: Seniors. (OALR, 2011, section 2.5.2)

Registrants must offer social and recreational programs that promote the mental well-being of residents.

Home and Community Care Policy Manual (Province of British Columbia, Ministry of Health, 2013, section 5.B.3)

Benefits include...access to basic activity programming such as games, music and crafts.

Forest Place Handbook **(p.15)**
A broad base of social, educational, spiritual and recreational programs are offered by qualified therapeutic recreation staff. A full calendar of activities...is available that encourage social interactions and support quality of life.

Jasmyne

Memo after fourth interview with Ian:

It strikes me that neighbourhood is very important for AL facilities, if the residents are meant to be independent and able to pursue their own social lives.... Ian clearly loves to be social and misses being where the action is.

Memo after third interview with Rose:

AL residents seem to be in an odd place, where they move in for health reasons but are considered independent so are somewhat left to their own devices socially. It's not enough to move people in and expect connections to occur. Space has to be resident-friendly and user-controlled.

Ian

Yeah, they have activities, in the dining room, which you see advertised... As far as I can tell there are only women on this floor, but they – they're not very spry. And, I've seen some other people and the people I see in the dining room, when I went there. I would say that as a facility, they offer as much as could be expected to be offered, or as there is available to these people, as much as they wanna take part in. But uh- - Well yeah, I mean there are organized activities, that's for sure!

J: Sound like nothing's really grabbed your attention –

I: No! No, I'm not interested in *bingo*.

Figure 7-3 Social and recreational opportunities

Taken together, the quotes in Figure 7.3 demonstrate several issues around the provision of social and recreational opportunities in AL. First, there appears to be a disjuncture between the requirement to provide “basic activity programming, such as games, music and crafts” and the suitability of this type of programming for a population whose abilities and interests vary widely. In their passages, both Rose and Ian identified the people taking part in “singsongs”, exercises and games as belonging to a different group from themselves. By referring to the participants as “they”, “these people”, or having “much more severe difficulty”, Rose and Ian demonstrated a narrative disconnection between themselves and the type of person for whom they perceived the activities were meant. Helen, who also lived in a campus of care facility, similarly reported that most of the activities offered at her AL were geared to the “complex care” residents. For example, the physical activity classes offered in Rose, Ian, Helen and Mabel’s residences were all based on chair exercises. As we read in Rose’s narrative, she was unhappy that different levels of intensity were not accommodated. She felt it did not require separate classes to do so, only that the instructor offered suggestions to modify exercises for more intensity. Helen reported that she did attend the daily exercise classes, “geared toward wheelchair people” and held in a separate complex care wing, but she supplemented them with her own exercises and going for walks. Mabel said that she enjoyed the Sit and Be Fit classes when she did go, but she had a different fitness level than either Rose or Helen: she used a walker, as well as a wheelchair when she was tired, and was beginning to find that even walking the path around the perimeter of the building was too tiring. Interestingly, Mabel lived in an AL-only residence, but the fitness classes were still geared to the lowest level of intensity. All three women were keen to maintain their physical health, but had different requirements from classes. AL operators should recognize this heterogeneity when designing exercise programs.

Second, some of the choices from the facilities I visited appear to represent stereotypical age-cohort activities, such as bingo and knitting, which echoes the findings of previous research in AL (Cutchin 2005; Dobbs et al., 2008; Jungers, 2010; Mulry, 2012). Reaction to the programming among my participants varied, but again, Rose, Ian, and Helen felt that the classes were geared toward a different segment of the residents than themselves. Mabel commented positively that there was "something going on all the time" at her AL, but she struggled to recall what she actually attended other than the live musicians who would come to play. She was clear, however, that she did not enjoy bingo. What appeared to be important to participants, on the other hand, were activities that supported individual interests and values, even if they were not offered in a specific class or group. Rose, for example, wanted to maintain her lifelong identity as a contributor. She did not want to be a passive participant of generic 'programming' – she wanted to help improve the environment in which she found herself and to create a community of caring. Ian wanted to engage and stimulate his mind – something his law career, his previous relationships, and civic duties allowed him to do – but his perception was that there was nothing like that on offer at Forest Place. He enjoyed his neighbourhood, though, where he felt he could go to seek conversation and be a part of the activity even by sitting on a bench. As mentioned, both Ian and Rose observed that the attitude of residents in Forest Place seemed to be that they felt "useless" (Rose) or that they were waiting to "go out in a pine box" (Ian). Similarly, Helen felt that people in her AL seemed to be "biding their time"; just eating and going back to their rooms. Offering different types purposeful activity, programmed or informally, should be an important consideration for AL operators. For example, research suggests that contributing through help with meal preparation or cleaning tasks can positively support AL residents' sense of independence and importance (Ball, et al., 2004) and help them create a sense of home in the

AL environment by putting their “personal stamp on communal spaces”(Lewinson, Robinson-Dooley & Grant, 2012).

Third, simply offering ‘recreation’ in AL does not necessarily translate into meaningful socialization. Fostering spontaneous, positive, lasting social connection requires more than simply seating people together at meals or scheduling directed group activities. The language of the Forest Place Handbook itself does not reflect a sense of fun or camaraderie in its programs, as seen in Figure7. 3. Rather, it promises to offer programs run by “therapeutic recreation staff” that support “quality of life.” As with the case of ‘nutrition’, experts in the field of recreation have the power to define what age appropriate activities are for residents. These may incorporate legitimate features of program design and evaluation, and future research in this area would examine the specific guidelines for recreation and activity in AL. However, using this organizational language in a brochure meant for older adults themselves does not seem terribly enticing for prospective participants who are more likely to be drawn by the potential for having a laugh or doing something interesting. Conceivably, framing it as ‘therapeutic’ programming could even be a barrier to participation for those who do not see themselves as needing therapy.

Part of the tension here is that AL operators are mandated to provide social and recreational programming, but as Rose said, the independent people “do go out.” There needs to be a way to uphold the independence of AL residents, who are presumed capable of making their own friendships and arranging their own activities, while facilitating in-house connections. Some of the solution involves providing the right kind of space for socializing to occur. Rose and I spoke at length about creating a physical environment where people could feel safe, private, and comfortable so that they *could* come together and get to know one another. Seating that was plentiful, flexible in number and motility, accessible for all physical abilities, and located in

quiet, cozy areas were all suggestions that Rose had to invite residents to linger in the otherwise open, busy spaces of Forest Place. Common areas are particularly important, because the participants I spoke with did not often visit suite-to-suite and therefore needed other options for getting together.

But fostering connections and self-directed socializing seems to require something more than just providing a pleasant space. For example, Helen's AL had a well-appointed lounge, which she showed me after our interview.

> They've got a very large room ... well stocked with games, and nice pool table, and you know. And it's not used. I can't understand it; very seldom. Well, I do. A group of us play Scrabble every evening and that's one social part. But during the day you go down there and there's nobody around, I can't understand it!

Further, Helen noted that, "It's really strange. Everything shuts down after eight o'clock; everybody goes to their room, goes to bed, there's very little activity after eight o clock." As a self-described social person, Helen even elected to make breakfast down in the lounge's kitchenette because she felt it was "a good thing to get out." She was clearly willing to socialize and was making use of the AL's facilities, but still did not find the social life she expected.

From talking to participants and also from walking around in the common areas of the AL residences with them, it seems to me that there are two interrelated parts to addressing the social atmosphere in AL. First, outside of residents' own suites, there is a strong sense that the physical space does not 'belong' to residents. In Forest Place, there are staff coming and going through the lounge and the dining tables are not available for socializing or informal activity. Rose talked at times about staff being resistant to arranging furniture differently because it would interfere with classes or schedules for the space. The penthouse was technically available for

resident use, but only when meetings or functions were not being held there. The conflicting priorities of staff and residents for common spaces have similarly been identified in research in AL (Andersson, Ryd & Malmqvist, 2014). Picking up on the notion of the affective environment, Ian and I were reluctant to fully explore the hallways and rooms on our tour of Forest Place, like we were 'snooping' in common spaces. In Helen and Mabel's lounges, the decor and furnishings were beautiful but the rooms felt static and not meant to be disturbed. As Rose described, she had to make a conscious decision to extend a friendly energy into the environment around her in order to slowly claim it as a space where she felt comfortable. Other residents might not be as astute or persistent about their role in creating a positive affective environment, and could remain isolated for much longer.

This leads to the second point, which is that AL residents do seem to need a way to come together and get to know one another, but with programming that is suggested or even delivered in resident-led ways. Forest Place appeared to have begun this process; during our last interview Rose said she was "delighted" that she had successfully worked to get the horticulturalist for the complex care residents to hold a class for the AL residents every second week. Management also quickly accepted Rose's idea of a buddy system for new residents to help them settle in. Another idea would be to enable residents to organize their own classes or workshops. Ian, for example, was excited to think about offering legal advice for a seniors' program at a community centre – it would have been even easier for him to participate if a program were held in-house. The benefit of hosting events open to the community would be increased social networking as well as allowing residents like Rose, with extensive volunteering experience, to continue to feel useful even if their health concerns made it difficult to go offsite to do so.

Returning now to the question of how the official, textual narrative of AL was referenced in participant accounts of relocation, my analysis indicates that the service delivery frame was dominant. Participant spoke about their motivation for moving in terms of receiving assistive services, not about accessing a 'retirement lifestyle' such as the more upscale, private AL brochures promote. At a basic level, accessing services was unproblematic – personal care, housekeeping, meals, and recreational programs were available to residents and were provided in accordance with provincial health and safety standards. Reflecting on *how* these services were provided, however, reveals that the ideological discourse of AL does not always translate into practice. Dignity, choice, privacy, respect, individuality, and independence are abstract concepts that were not typically referenced in those terms, but participant narratives illustrate areas where these values were met with greater or lesser success. In the context of AL, it is difficult to isolate these values for discussion – having one's own suite supports privacy as well as individuality and independence, for example. However, 'choice' emerged as one overarching theme that incorporated many of the satisfactions and disappointments participants spoke about. From the beginning stages of selecting (and being selected by) an AL residence to the process of settling in to the new environment, the perception of having choices that matched the participants' expectations and personal preferences was an important theme in the narratives. Care plans, for example, were viewed with a level of satisfaction because of participants' perception that they were gaining a service and that at least parts of it could be negotiated, and that care staff interactions were viewed mostly positively. Mealtimes, for those who were still interested in cooking, were viewed with less satisfaction because they did not meet with residents social or dietary expectations. Participants also mentioned times where personal choice was constrained by organizational (service delivery) structures, such as having to do one's laundry at a set time

every week, being discouraged from the stairwells freely in the name of ‘risk’, and having to use certain utility companies at a facility-negotiated rate.

Yet most of the participants were still able to accept the move and find ways to view it positively. Rose, for example, continually chose to make the best of her move to Forest Place. Even though she considered putting herself on a waitlist for another AL partway through her first year there, as soon as she was consulted for her input through the Food Committee and the Operations Committee, she elected to stay. Ian faced the same organizational structures in Forest Place, but his account was quite different from Rose’s. Narrative and gerontological research provides insights as to why this might be the case. In the following section I will explore the participant narratives in terms of their construction, as well as the personal contexts and available discourses that influenced how Rose, Ian, Mabel, and Hazel spoke about their relocation. My goal is partly to untangle the discourses about ageing woven into participant narratives, and partly to investigate the dynamic ways that older adults grapple with relocation as part of their life narratives.

7.2 Participant narratives: What do they tell us?

7.2.1 Narrative construction

As Reissman (1993) asserts, narrative analysis is not only about content. “We ask, why was the story told in *that* way?” (original emphasis). Rose and Ian, for example, told distinctively different stories, not in just terms of content but in terms of style and theme. Looking to qualitative and narrative research there are some suggestions as to why this was the case. First, Gubrium and Holstein (2009) advise researchers that narratives “emerge in context” (p. 42), so the conditions of the telling must be taken into account during analysis. Rose was clear the first

time I spoke with her that she was interested in telling her story so that she might help improve the moving and settling in process for others. While her story was personal, it also highlighted particular aspects of the AL system she felt were important to address. Time spent in our interviews discussing these aspects was an extension of the conversation she was attempting within Forest Place. Our interviews always included updates on organizational goings-on and any other critical insights about AL or her situation that she had developed in the interim.

Ian, on the other hand, framed his interest in participating as wanting to be helpful. He felt empathy for me as a fellow student of his alma mater. He spent time between interviews thinking about what to tell me that I might find useful, and whether or not he was even a suitable participant. The topics of our interviews were less spontaneous and more closely related to clarifications or questions generated by me. But participating in the study was also helpful to him, I believe, because he was seeking mental and social stimulation. In our later interviews he seemed to be very engaged in reflecting; it often seemed like it was the first time he had considered how he felt about certain transitions or experiences.

Research suggests that gender may also have informed participants' perspectives on moving to AL and the shaping of their narratives. For example, Rose was able to continue express herself in terms of "house, community and family", which Seipke (2008) found to be important to women who moved to AL. Maintaining a degree of control over traditionally "feminine sphere" activities (maintaining a household and family and having community engagement), even in a "downsized" way, tended to inform the strength of the participants' sense of self when faced with a new environment. Through cleaning and cooking for herself as much as possible and through her continued importance to her family, Rose was able to preserve her self-identity and enact her values of caring and doing. Her sense of satisfaction increased further

when she had an outlet for her love of community and service within Forest Place. Similarly, Mabel and Helen spoke highly about the role their families played in supporting them and gave anecdotes that demonstrated frequent contact with them even after relocation. Mabel had even been able to continue hosting out-of-town family through the use of a guest suite at her AL residence. Both women took pride in decorating and caring for their suites. The furniture was tastefully arranged with mementos displayed; Mabel even had curtains made with fabric brought by her granddaughter. Helen continued to do her own laundry and both women mentioned that they chose to make their own beds. Helen also appreciated being able to continue her routines in the community such as banking and shopping. Their families, routines and environments therefore seemed to provide a sense of groundedness that helped them adjust to life in AL.

The work of Park, Knapp, Shin & Kinslow (2009) indicates that there may be different criteria for men's satisfaction with AL. When reading the comments from that study's participants, I was struck by the similarity with Ian's narrative. For example, male participants had difficulty forming satisfying relationships within AL residences, in part because they did not regard many other residents as being as mentally capable. Like Ian, some men became friendly with staff instead, whom they perceived as possessing sharper minds and more willingness to engage. The authors also suggest that the social and recreational opportunities offered in AL did not match men's preferences. In particular, bingo was an activity most men avoided, and although they appreciated musical entertainment, it was not viewed as "meaningful." As well, the men discussed the need to "escape the day-to-day sameness of the facility" (p. 777). Similar to Ian's assertion that his scooter and neighbourhood made his life "unbelievably more pleasant", there was a strong desire for the men to leave the AL and interact with the outside world. Also discussed by Park et al (2009) is the fact that men are statistically less likely to have the type of

close relationships and involvement with grandchildren and adult children that women do. The women's narratives demonstrated regular and emotionally meaningful connection with their families; Ian's narrative indicated that he saw his grandchildren less often than he expected, and had a more restricted type of communication with his children. Ian therefore faced a 'double' isolation in that he did not have close family relationships and also could not find one in Forest Place.

Narrative gerontological research has also begun to investigate patterns of life story construction and how this connects to individuals' attitude toward and experience of ageing (Bohlmeijer, Westerhof, Randall, Tromp & Kenyon, 2013; Freeman, 2000; Freeman, 2011; Randall 2013a; Randall 2013b; Randall, Baldwin, McKenzie-Mohr, McKim & Furlong, 2015). One example is the concept of *resilience*, defined as "the capacity for coping with the challenges of later life with openness and positivity" (Randall, et al., 2015, p.155). A recent study on the narratives of older adults with high and low scores on a resiliency scale suggests that individuals with high resiliency scores tend to tell self-narratives that are " thicker and richer, more detailed and complex in nature, and—so to speak—stronger overall" (Randall, et al., 2015, p.155). Aside from the length and multiple sub-narratives in Rose's moving in story, her narrative reflected several qualities that were typical of high resiliency scorers in the study: a sense of agency, openness and positivity. She demonstrated her sense of agency when she talked about how she coped with being a single mother, how she maintained authority during her move to Forest Place despite her injury; and her conviction that she could personally effect change in Forest Place. Even her future death was viewed positively, as she knew her ashes would be reunited with those of her parents and grandparents in the beautiful "Bluebell Woods." Her willingness to seek out medical marijuana shows open-mindedness, and her positivity was apparent in her self-talk

before moving to Forest Place and her campaign of friendliness after she moved in. All three aspects of narrative resiliency are also evident in Rose's description of living with rheumatoid arthritis; she was experienced in dealing with pain and also in coming up with creative solutions and ways to stay positive. Having a pre-existing narrative tendency toward resilience would have helped Rose to integrate her new life in AL with her previous sense of self.

Helen also demonstrated aspects of resilience in her narrative. Like Rose, Helen referenced her family of origin and spoke admiringly of her parents, particularly her mother. Just seventeen and the mother of a three-day old baby when she left Russia, Helen's mother sewed seeds into the hem of her skirts "because she didn't know what she would find in the new country." Later, she learned to read with her eldest son's school books and the Eaton's catalogue. Helen linked her own sense of adaptability to the modelling provided by her parents:

> My parents were immigrants from Russia, and they adapted to a new county, new language. And uh, we just learned it. My mother was very innovative. She used to read the local papers, the woman's page, and she learned to do her, her canning, and processing vegetables and fruits through the women's pages, she'd say, "If they can do it, I can do it!" And away she'd go! Did everything.

Helen also referenced her brother, who taught himself to play violin, and her sister, who overcame childhood polio and the experience of flooding in her home at the age of 89, as examples of how people in her family persevered. In her own life, she chose to join the Canadian Air Force in WWII, which she said was "a big transition, and an education" that she ultimately enjoyed. She continued to defy traditional roles by taking a commercial course when the women's division was disbanded, and she worked as a school secretary while raising her children. Helen therefore felt comfortable describing herself as "adaptable" and "resourceful",

which she said helped her adjust to life in AL. I asked her if she had any advice for other people considering such a move, and she said, “Well I would only say, go ahead with an open mind. You know, you *know* there are going to be changes, you might as well accept them” (original emphasis).

Mabel’s narrative also demonstrated the qualities of agency, openness and possibility. Her story was populated by characters and anecdotes from her life, both past and present. She seemed to have a realistic approach to ageing (discussed below) and she described her philosophy for getting settled with the people and life in AL as, “You have to try.” It had been her decision to move to AL and descriptions of her relationships with family and staff showed that she felt comfortable expressing herself to them. In turn, they respected her decisions and supported her sense of agency. From these examples, it seems that the women had an inner orientation towards resiliency that helped them when relocating to AL.

Aspects of Ian’s narrative, on the other hand, exhibited some qualities common to the participants with lower resiliency scores, such as a less optimistic tone and also a sense of poor self-esteem (Randall et al., 2013). Unlike the women, he made no mention of using a positive attitude to help him in adjust to life in AL. Instead, he seemed pessimistic about finding a way to resolve his dissatisfaction with aspects of his life and often his accounts ended with resignation (e.g. “I see no solution to that”; “This is your lot in life”). Upon reading the transcript of our first interview he commented that he sounded like a “blathering idiot”; in another interview he blamed his “own stupidity” for scheduling our appointment at the same time as a televised golf tournament. In other cases, he questioned whether his story would be of any use to me. These examples indicated to me that he might have a negative self-image, which could be related to another noticeable feature of his narrative – a lack of agency. He did not seem to have the same

sense of participation and control in his own relocation narrative as the other participants; his story was marked by a number of events where others made decisions for him rather than with him. In other cases, the structures of policy or regulation inhibited what he would have chosen to do, such as the amendments to the legal acts that ended his law career prematurely. Compared to Rose, Ian's relationship with Forest Place was more tenuous and subordinate. He felt as though he could be evicted for using his kitchen, he was unsure of exactly what constituted "assisted living", he referred to people in management as the "big shots" or "big wigs" and he wondered what his "report card" said about him after living in Forest Place for four months. Unlike Rose's family, his family seemed to accept the rules and regulations of AL much more easily and advised him to "be the perfect little tenant" in order to avoid any difficulty.

These features in Ian's story reflect another concept from narrative gerontological research, that of *narrative foreclosure*. Developed by Mark Freeman (2000; 2011), narrative foreclosure describes a phenomenon wherein an individual views his or her life story as effectively over. It captures "the conviction that no new experiences, interpretations, and commitments are possible that can substantially change one's life-story and the meaning of one's life as it is told now" (Bohlmeijer et al., 2013, p.367). As Freeman describes, narrative foreclosure is in part related to the internalized "cultural storylines" (2000, p. 83) around what an individual expects for themselves and the future. If this future does not manifest or is prevented from manifesting by unexpected life events, an individual can experience a sense of existential despair or loss of momentum. As mentioned in Chapter 6, at one point I asked Ian how he saw the current period of his life; whether he was looking forward to anything or had any plans. He simply responded, "No." He also initially he said that he had no previous expectations for retirement and old age, but further exploration of the topic suggested that he did have an

internalized, upper-middle class storyline, similar to that of the 'third age', for this time of life. The loss of his wife, followed by his boat, his career, his health, and his income were turning points which appear to have greatly altered what he had assumed his later life would be like. Freeman (2011) suggests that "looking backward, one can sometimes see certain features of the past for the very first time; and while the result can be great joy and gratitude, it can also be the deepest pain and regret" (p. 10). While Ian did not appear to regret the time that he spent caring for his wife, he did seem regretful about the loss of contribution to his RRSPs and his decision to quit his firm, which influenced the lifestyle he was subsequently able to afford. He saw few options for meaningful pursuits because the things he enjoyed or wished for, such as boating or living in his own apartment with a housekeeper, were associated with financial resources.

Ian also experienced a different kind of narrative foreclosure, described as a situation where

> key people *foreclose on* older adults, so delimiting or dominating their narrative development – telling them in so many ways what to think and do, insisting that their version of old age is the version of old age – that, effectively, older adults' stories are not their own. In that case, other people do not co-author narrative identity so much as co-opt it. (Bohlmeijer et al., 2013, p. 367, emphasis added)

In Ian's narrative, the actions and the voices of his local son and daughter restricted his agency in several areas. While Ian was ready to find a new companion, for example, the censure of his family over the age of the women he started to get to know meant that he was not supported in his efforts to take care of his need for intimacy. To Ian, this was a profound problem that he could not get his "mind around" and which was compounded by the fact that women of 'appropriate' age in Forest Place were not interesting to him. He said

> I've stopped to talk to a number of them. And they strike me as, as being like [my wife] in her uh, in her stage about the time when she burned the f-peas. I don't know whether they have dementia, or what, but- You know, if I raised the question of what do you think about what's going on in the States, you know...They wouldn't know what I was talking about.

In other cases, his family's inaction limited his agency. For example, he was upset about the loss of his self-made cookbook, but his family did not seem to understand the importance of it to Ian or make an attempt to find it: "And do you think my daughter would admit seeing it? *No way*, not my son, *anyone. No one*. So. (original emphasis)" The book was symbolically important to Ian as he moved to Forest Place; together with the full kitchen it represented a new beginning of being independent and reclaiming a meaningful activity. By not attempting to track down his cookbook, Ian's family constrained his experience of gaining a kitchen. His family also seemed to minimize his concerns with Forest Place when they went for the tour. In their (inaccurate) assertion that all care facilities were the same in terms of atmosphere and functional ability of residents, they told *him* what to expect from ageing, and how they implicitly viewed him (i.e. as being in a state of decline).

Certain organizational structures also limited Ian's sense of agency and authorship over his story. For example, the mixed messages about using the kitchen in his suite altered Ian's excitement over cooking. He resisted the staff member's discursive attempt to enforce complicity and went on to use his kitchen, but the joy of it seemed clouded by having to approach it in a clandestine way. Importantly, Ian had already spent several years in various care settings, subject to the authority of biomedical assessments, facility routines, and staff. The example he gave of bathing at the first AL he lived in after the hospital demonstrates the complete lack of authority

he had over his own body and the power wielded by medical staff. In another example he spoke of how little faith he had in resident's councils to effect any real change in facilities. Such examples raise questions around what the cumulative effects of living in a series of regulated environments may have had on Ian's sense of narrative ownership; it may have made him less optimistic of what possibility he really had for directing his life in the face of the residential care system that had swept him along thus far.

Ian's response to these two varieties of narrative foreclosure seems to have been passive resistance. Although he had asserted himself before moving and insisted that he have a suite with a full kitchen, once he was at Forest Place he seemed to find few avenues left in which to challenge the expectations around him for old age as a time of decline and receipt of services. His response was to withdraw from the communal activities of Forest Place and instead, privately cultivate his political interest and knowledge by following current events and seeking connections with care staff and people in his neighbourhood who could participate in the discussions he sought. In so doing, he separated himself from the other residents whom he viewed as less mentally capable, and maintained his intellectual self identity. He spoke of himself as a lawyer in the present tense and he kept the box of files for his remaining client. On his scooter he was self- sufficient and could enjoy his neighbourhood and attend appointments. He may have felt lonely at times, but he seemed to prefer his own company rather than compromise his standards for companionship. I believe he retained pockets of hope and interest in making connections, as demonstrated by his enthusiasm for the law clinic I mentioned. In these small ways, Ian was able to stay connected to the world and resist total narrative foreclosure.

7.2.2 Discourses of ageing in the narratives

Having discussed the qualities and construction of the participants' stories that might be helpful in understanding why they responded to relocation in the way they did, I would like now to turn to an examination of the narratives to draw out the implicit and explicit discourses of ageing. Insofar as relocation to the age-segregated environment of AL can be considered a social marker of being 'old', it is important to pay attention to how individual conceptions and expectations of ageing align with the ways that society responds to and cares for older adults.

Early in my interviewing process, I found it difficult to prompt participants to talk about ageing. Like a researcher studying the influences of 'culture', 'ageing' seemed to be so ubiquitous to the context that it was only obvious to me, an outsider, that it should have any place as a discrete topic. Beyond using the language of 'seniors', the AL documents make almost no reference to ageing. The one exception to this is the *Forest Place Handbook* and the opening passage that states "aging is a normal human experience and the gradual fulfillment of the life cycle" (p.2). To the participants, they were simply themselves as they had always been. Age and age related-changes were part of the shifting context of their lives, but being 'old' was not their primary identity. As Ian stated, he had never been 85 before, so he was not entirely sure if he ran out energy *because of* his age. But through some direct questioning and by paying attention to cues in the data, I was able to hear the ways that participants talked about ageing individually and some of the dominant ageing discourses used in the course of their relocation stories.

The most common reference to ageing across the narratives was in respect to ageing bodies. I asked participants whether moving to assisted living had made them feel their age more; I thought that perhaps being in such an age-segregated environment might have such an effect. Instead, they responded that it was not the move itself but the change in their bodies and

function that caused them to feel old. Mabel had noticed that she was finding it harder to walk the full walking path around her AL residence, and that she had to take care to not "overdo it." She said at times she missed being able to go out for walks in nature as she had done all her life, but pointed out that it would have been the case no matter where she lived. As mentioned, Ian noticed that he would feel "bushed" after a few chores, and that he did not have the same stamina for walking or standing as he had even several months earlier. Rose said ageing just "happened more" around the time she moved to Forest Place; her rheumatoid arthritis and osteoporosis progressed and she soon developed osteoarthritis.

Participants used a variety of strategies to make sense of and cope with these changes. Mabel for example, described an attitude of acceptance, even though it was "hard" at times. As she said, "Well I know I have to slow down; you just do, you accept what's happening to you. At least I do, I know some people resent it but that's life! I mean, you're born, and you die." She appreciated her AL residence because she had not been managing well on her own, and in AL she was able to concentrate on those things she could still do for herself. She even appreciated using a wheelchair at times:

> The wheelchair was my choice. [The manager], well she doesn't mind that I use it but she wanted me to be as much as I could with the walker...But it's kind of nice by the time evening comes to sit in that chair and wheel myself down for dinner.

Rose, Ian and Helen, however, seemed to use a different strategy to reckon with their age-related changes. I noticed they would make direct and indirect comparisons between their own capabilities and those of other residents. For Rose and Ian, this began as soon as they had their tours of Forest Place. Ian remembered walking through the lounge and noticing that "half the chairs were full of people who obviously didn't know who they were or where they were",

which he said would have made him reject the place were it not for the in-suite kitchen. Rose said she looked in at a program underway and thought to herself that it was nice that Forest Place was "looking after these people", who she said were "obviously in a different condition than I was." Understandably, Forest Place is a campus of care so Rose and Ian might have needed to remind themselves that they were being admitted to AL and not complex/long term residential care. But the discursive separation of "people like me" and "them" remained even after they had been in Forest Place for several months, as demonstrated in the previous discussions about dining and social/recreational opportunity. For example, when Rose was helping to redesign the Forest Place *Handbook*, it was very important to her that at least one of the cover models was walking independently – "They don't want to take one look and think, "Oh my God, I'm the only person who can walk in here! You know? That would be a bit horrifying." But where Rose was eventually able to identify other AL residents specifically as being "people like me", Ian saw little distinction and was equally dismissive of those on his floor whom he said had "no spunk" or who were not very "spry". Arguably Ian, who needed a scooter to get around, was also not very spry, but he did not count himself among 'them'. Helen also lived in a campus of care, and joked that she wished she had bought shares in a walker company, "Because, my goodness there are a lot of them here... I feel pretty good about walking." She used a cane when she went out to run errands, but she made it clear that she did not use it around the AL residence. So on the one hand, Ian, Rose and Helen recognized that they had experienced age-related changes, but on the other hand they were not yet willing to see others' reduced capabilities as a possible trajectory for themselves. Arguably, this reflects the positioning of age that has occurred through the popular discourse of successful ageing – the label of 'old' is simply pushed onto higher age brackets or to those with the most frailty and therefore maintains its stigmatizing connotation.

Given this negative discourse around ageing and decline, it is not surprising that participants chose to distance themselves from others who were perceived to be frail or 'less able'. For all participants, the strongest separation from 'them' was reserved for residents with dementia or other cognitive impairments. Language to describe the afflicted ranged from sympathetic ("poor soul"), to paternalistic ("dear little lady"), disapproving ("She'd pick up her fork and clean her nails") and dismissive ("vegetables"). In this area, participants mirrored wider, "hypercognitive" (Post, 2000) values and social responses to people with dementia. Helen, who had witnessed the trajectory of dementia through caring for her mother-in-law and her husband, framed her own relocation as less "traumatic" than theirs because she had retained control and capability through her transition. She felt reassured that she would not have to face that fate, because dementia did not run in her family.

The participant narratives also echoed some of the other ideas present in the active/successful ageing discourse, such as staying busy and keeping healthy, but I did not get the sense that this was an overt attempt to avoid becoming one of "them." It would be hard for participants to be unaffected by such discourse, given its ubiquity in public policy and popular culture. But, it also seemed that they were interested in maintaining independence, health, and quality of life for their own sakes and because these interests intersected with lifelong habits and beliefs. This seems like a more positive interpretation of successful ageing, where individuals are simply interested in ageing the best way they can, rather than trying to avoid or deny a natural process. While Ian apparently did not pursue exercise classes or otherwise work to maintain his physical function, he was concerned with sustaining his mental stimulation and social engagement. Rose and Helen took purposeful steps to manage their bodies through diet and exercise because, as they expressed, it helped manage their health conditions. For Rose in

particular, doing so was a way of life cultivated over many years. She provided me with a humorous anecdote about initially refusing a wheeled grocery cart that her children wanted to buy her, because she felt that her posture was better when balancing two, evenly-weighted grocery bags. One day, however, she glanced in her bathroom mirror as she walked by and noticed with a start that she had "wings" – she was walking with her arms back and a bit bent at the elbow as she hunched. It seemed to be a visual shock to see herself in such a stereotypical 'old lady' pose (my words) and she vowed then to get a wheeled cart to help remind her to stand tall and keep her shoulders down as she walked. On the one hand, her reaction could be interpreted as vanity, or as internalized ageism. But the way Rose framed it, she had already lost some of her posture and mobility to the effects of polio, arthritis, and osteoporosis and she did not intend to relinquish any more if she could help it.

Some participants referenced other aspects of ageing that they found challenging. Ian described feeling "old" partly as a result of his social marginalization and diminished capacity in the world ("There's things I want to do, and I can't do them!"). He seemed disillusioned that his third age reward of a 'good' retirement had been thwarted through a combination of events. As mentioned, he had expected to spend his later years enjoying leisure pursuits and the companionship of his wife. Instead, he felt hampered by his lack of financial resources, which contributed to the diminishment of his autonomy across several areas such as choosing his residence, hobbies and partners. Once his children were involved in his finances, it seemed they had greater leverage to censure and influence his actions. The other component in Ian's marginalization was his disconnection from a social circle or the wider community. He enjoyed the social outlet that going out in his neighbourhood afforded, but he was candid about being lonely and mentally under-stimulated.

Like Ian, Rose also spoke to a sense of stress related to income. As discussed in the previous section, she was frustrated with the increase in her telephone bill because it further limited her already tight budget. Not only was she paying for the monthly AL fees and her prescriptions, she was not able to opt out of the meal plan so she was also paying twice for her food. As highlighted in Chapter 2, age is often conflated with poverty and being a burden on society. Yet Rose's account shows that the relationship between poverty in old age is more complex than the popular discourse of age and dependence would have us believe – it is at least partly related to our system of health care and social welfare funding.

Moving out from the direct voices of the participants to examine how family, AL staff, or other health care system workers were discursively represented, the narratives reveal the positive and negative influences that those on the 'outside' of ageing had on the lives of participants. For example, family could be a great support during and after relocation, as they were for Helen, Mabel and Rose. Their children helped research and physically move their parents in, but importantly, left the final decision about which property to the women themselves. Ian's children, on the other hand, counselled him to "lump it" at Forest Place and "get on with" the process of relocating. Where Rose's children gave her the support to challenge rules and speak her criticisms, Ian's children advised that he not make waves. By virtue of participants' relocation into a regulated living environment, health care workers and administrators also had influence over their lives. Decisions around what constituted 'risk' (i.e. the locking of the stairwells), meal plans, dining partners, and who could enter and remain in AL were made about, and for, residents, usually with minimal consultation. Although they had attended Resident's Councils, Ian and Helen made comments indicating that they were not true forums for input and change; Forest Place's AL management appeared to be an exception to this because they worked

with Rose to implement some of her suggestions. What the participant narratives show is that, even though a degree of organization in congregate living is necessary, older adults continue to want to be involved in the process and procedures of their lives.

Another outside influence was the looming possibility of moving yet again, should their level of disability increase or, as Ian feared, he was found to be unsuitable in some way. The potential transience of the stay in AL was common across all the relocation narratives. Helen summarized her position as being settled in her AL, which she felt it was "a good transition from your own home to the next level. Hopefully you don't *have* to make the next level, but..." (original emphasis). Mabel also said that she did not "look forward maybe coming to be looked after; I hope I don't." Rose said that one other reason for choosing Forest Place is that she could just move down to complex care if need be. Perhaps the threat of being relocated was part of the reason Helen, Ian and Rose compared their ability to other residents' inabilities; it was a way of measuring how far they had yet to go before moving to complex care.

Philosophically, a discussion about ageing or physical decline often leads to a discussion about mortality. I did not bring this up with my participants, yet the topic surfaced in each account. Ian mentioned it in a spontaneous, unembellished fashion when responding to one of my questions ("I'm here to die"). In other cases it was related to the recognition that, in order for someone to move in, someone must move out. Helen remarked, for example, that her AL was referred to among residents as "God's waiting room." She also spoke about caregiving for her parents-in-law for the few years before their deaths in the context of her own experience with ageing and complex care. Rose and Mabel reflected on the passing of their family members and held them as examples of a 'good' end of life. Mabel said

> Do you know what I want to do? Sit here and go to sleep (palms up, hands down by sides in chair). You know my dad did it. You see, he was very good up to the end, and I don't remember of course but apparently he just sat in his chair and went to sleep! Isn't that perfect? But you don't have a choice but that's my wish.

Rose gave a beautiful account of the family spot in her native England where her grandparents, father and brother-in-law have all had their ashes placed:

> When my granny died, she had always loved what we called Bluebell Woods because they've got those beautiful old, old, old trees, and they get *covered* in bluebells and cowslips ...And they've got deer, roaming around and they've got bar lands and they've got beautiful fountains and everything, so. And granny would love going through the forest; we used to push her in the wheelchair. And so, we put our ashes there... We decided long ago; might as well all be together. And it doesn't make me feel sad at all, I think this is lovely! (smiling) I'd be quite happy being here, have a good old talk to them! (original emphasis)

The ways that participants constructed their stories demonstrated ageing to be a personalized, contextual interpretation that is mapped onto the existing terrain of public thinking and policy about the 'old'. For these individuals, their unique biographical and biological experiences of ageing also had to incorporate the transition into AL, with its own messages about what older adults can expect at this time of life. Specifically, the process of assessment and service provision in AL sends the message that other people will now be responsible for organizing the lives of older adults – meals, recreation, limits to service delivery, and administrative priorities such as health and safety formed the context in which participants now found themselves. Rose, Helen and Mabel seemed to have an orientation to resilient ways of

approaching this event, where Ian felt a sense of fatalism and disempowerment in the process. I did find traces of wider discourses of ageing across the narratives, such as the biomedical focus and ageist assumptions of the elder care system, as well as the stigmatized position of frailty in our society. But I also found examples of acceptance and bemusement around ageing, and a new understanding of how we really are just ourselves as we age, only older.

Bringing together the discursive story of AL and the stories of all the participants has illuminated the particular challenges that older adults face in relocating as well as the influence that relocation has had in forming the participants' experiences of ageing. The questions that remain have to do with how the context of AL, and the opportunities for older adults who move there, could be improved so that incorporating this transition into life narratives would be more positive than negative. Is AL fulfilling a unique purpose in the spectrum of support and care for older adults, or is it repeating the negative features of long term residential care? These findings have also made me think about how narrative methods may be useful in generating a larger cultural discourse of ageing that is generated from real experiences, rather than from biomedical, economic or successful ageing rhetoric. I turn to these questions and ideas in the final chapter.

Chapter 8: Summing Up and Looking Forward

The purpose of this study was to explore older adults' experiences of relocating to AL. In particular, I wanted to know how the founding philosophies and the available information about AL compared with the personal accounts of older adults who had recently moved there. Given the variation in operational models for AL and the historically small amount of gerontological research incorporating older adults' own voices, this study is valuable for its contribution of local, contextual and experiential data to the developing literature and knowledge of AL in British Columbia. My research examined older adults' narratives of relocation and the ways that they referenced AL and ageing within them. Interviews with the case study participants were gathered over the course of months, which added a temporal dimension to the description of their settling in process that is not typically found in the transition literature.

This study also addresses several other gaps identified in the literature on AL. First, it specifically investigated how AL-specific policies are shaping residents' experiences. While a handful of studies have similarly highlighted the need for meaningful choices and more consideration around social connection in this environment, this study is unique in comparing the textual discourse of AL to participants' lived experiences. In doing so, I found a tension between the values that AL is purported to offer and the ways that these values are operationalized at the level of the individual. Participants' expectations matched the AL rhetoric around independence, for example: relocation was accepted as a way to access the help or services they required while retaining much of their independence. However, their experiences drew attention to the ways that independence and choice were subsequently constrained by organizational policies.

This links to a second contribution of this study, which is that it shifts the focus of what is provided in AL to consider *how* it is provided. For example, my findings suggest that perhaps 'independence' in AL would be better conceived in terms of a relational approach, and that offering 'choice' will necessitate a more sustained and open dialogue with residents about what those choices are.

These considerations are in turn related to a third area of learning, related to social work. Social work has not had a strong presence in AL in British Columbia, beyond initial placements and ongoing financial or functional assessments. My findings suggest some areas where the expertise of social workers would be particularly useful, such as offering emotional and practical support after relocation, or building capacity among residents to make connections and claim a space in the AL.

Fourth, the study also begins to outline some more overarching questions and observations about the project of AL and its place in the continuum of supportive housing for older adults in British Columbia. To date, there have been few critical investigations into how AL, as one possible model of elder care, is serving the need of older adults or how it may be replicating some of the more undesirable aspects of long term residential care. My study suggests that perhaps the discursive construction of AL as preferable to 'nursing homes' has obscured what has actually happened in the industry. Much as there has been a movement to improve long term residential care in the past several decades, my findings suggest that it may be time for a critical appraisal of AL.

Finally, in addition to insights around the AL experience and industry, this study also makes a contribution to understanding the value of narrative as both a research method and mechanism for connection and change. As a method, narrative research is adept at capturing the

complexity and emotion of older adults' experiences. Different formats of narrative representation and sharing offer the potential to bring these experiences to a wider audience and help to change mainstream perceptions of ageing. As a means of creating dialogue and fostering connection between individuals, narrative is also a potentially useful tool for AL operators wishing to improve the lives of residents. Literature on AL typically does not position AL residents as members of a built community, but findings from this study suggest that generating spaces for residents to share experiences and knowledge could be empowering for peers, informative for operators, and useful in fostering a mutual sense of connection to place.

In this chapter, the findings and discussion related specifically to AL will be presented in the first section. In the following section, aspects of the findings related to narrative research and platforms for older adults to share their stories will be explored. The chapter concludes with practice and policy recommendations suggested by a combination of research findings, participants themselves, and literature. I also present ideas for future research, and offer some final thoughts.

8.1 Findings related to AL

My research found that while it was not somewhere they ever imagined living, participants generally accepted that moving to AL was a compromise through which they could access certain resources, such as 24-hour assistance or flexible (and in Ian's case, affordable) personal care while also retaining some independence, especially in their private suites. They expressed a sense of appreciation that they were not living in long term residential care, yet the limits to allowable care levels and the uncertainty of one's physical health meant that the possibility of long term care still loomed on the horizon. Moreover, other organizational

constraints, such as set menus and activities, marked the autonomy of life in AL as distinct from the autonomy of living in one's own home. In spite of this, most participants demonstrated at least some aspects of being settled in several months after relocation.

Holistic models of transition recognize that it is a multi-dimensional process that may involve ongoing negotiation. As a result, the ability of individuals to move to a state of resolution and reintegration after disjuncture can vary; some individuals like Ian can remain in a liminal state indefinitely. In this study, there were two main areas that were related to greater or lesser feelings of being settled in to the new environment of AL. In particular, the themes of **(meaningful) choice** and **connection** encompass the key structural, environmental and socio-emotional components of AL that participant narratives highlighted as influencing relocation experiences.

8.1.1 (Meaningful) choice

Choice is a major discursive theme in the promotional and regulatory literature of AL. It is part of what conceptually distinguishes AL from long term residential care even if, in reality, the available choices are restricted by health and safety regulations, personal finances, geographic location, waitlists, and other structural impediments. The perception of AL as an environment of choice is partly fuelled by the marketing of for-profit 'retirement communities' that incorporate the ideals of the third age – the pursuit of pleasure, self-improvement and an unfettered lifestyle. Publicly subsidized AL facilities do not advertise in the way that private pay operators do (i.e. on billboards and in newspapers) so the image of private AL becomes a mental reference point for the whole model of care. For example, Rose and Ian both expressed a sense of disappointment that, at the time they were looking to relocate, they did not have access to one of the limited number of subsidized suites in some more high-end, private pay properties. Forest

Place, in their estimation, was a lesser substitute for the lifestyle they could have had elsewhere. In participant narratives, choice was discussed in relation to three main areas: choice in moving to AL, choice during the settling in process, and the role of choice in maintaining continuity of self.

Even before they arrived in AL, choice (or the lack of it) had a major influence on participants' relocation experiences. In both private and public AL documents, there is a sense that older adults will be able to choose when and where to move, and that they will be able to select the residence that best matches their needs and preferences. Mabel and Helen were able to do this because there were desirable AL options in their area and they were in a position to pay privately for the residence that they preferred. Importantly, they had also decided for themselves that the time was right to relocate. Ian did not have the same opportunity to look back and accept that he made the right decision for himself, having entered AL directly from hospital and then relocating two more times under the influence of his children. Rose, on the other hand, could frame her move to Forest Place as a choice she made to be closer to her family and to ease their worry, which sustained her during her difficult first months. In 'choosing' Forest Place itself, both Ian and Rose were less satisfied than Mabel and Helen with their options and, as mentioned, would have preferred alternate facilities if they had been able to pay privately or remain on the waitlist for several years. Whereas promotional materials from private AL operators encourage tours to help older adults pick the best option, Rose was particularly upset that she was not allowed to tour the public AL sites until after she had been added to the waitlist. In her mind this diminished the sense of a true choice ("It is a stab in the dark"). Examining this practice from a critical perspective raises questions around the power of financial status. The assumption from publically subsidized facilities seems to be that 'beggars can't be choosers' and so there is no

need to extend such pleasantries. In all cases, though, the choice of facility was not strictly up to the participants, because AL administrators ultimately have the right of refusal. As well, operators at that time were able to offer only two of six possible prescribed services, which effectively limited care choices at a structural level.

Choice continued to be a factor in how residents settled into their new environments. Most participants felt that they had a choice in deciding how their care plans were constructed and carried out, which brought a measure of satisfaction. Choice was also supported through having one's own private suite, a space to furnish with cherished belongings and occupy according to individual preferences and daily rhythms. This feature enabled participants to immediately recreate a sense of home, at least in one part of the AL. As Rose's poem expressed, her apartment was a place to which she could retreat and forget about the wider AL environment beyond the door.

The sense of choice around dining and food was more varied, however. Mabel, for example, had decided that she no longer had the energy to cook for herself and so accepted the meals at her AL residence as part of the services she gained from relocating. At the same time, she spoke about missing certain choices, like enjoying a dessert on a day when she felt like one, rather than when it was on the menu rotation. Helen missed cooking, and wished she could at least be served meals that met her nutritional preferences if she was not able to make them herself. Rose found both the options and the quality of food at Forest Place to be lacking. Rose and Ian enjoyed an alternative to dining room food, however, and spoke highly of the choice they had to cook their own meals in-suite. For Ian, the one aspect of relocating he felt he had controlled was stipulating that, if he had to relocate to a subsidized AL, he would only accept a

suite with a kitchen. Both Rose and Ian felt engaged in maintaining their own healthy diets and found satisfaction in cooking as an activity.

Participants felt varying degrees of choice around available organized social and recreational offerings. Aside from access to personal care, social and recreational opportunities are held up as a major benefit of living in AL. In the promotional and regulatory discourse around AL, congregate dining is one route to fulfilling this goal, but my data showed that random assignment of dining partners could actually inhibit social connection because of differences in care levels and mutual interests among diners. Ian, for example, stopped going to the dining room for meals because he was tired of being, as he perceived, the only one to make an effort to socialize at his table. Rose had similar difficulties connecting at her table but found that when an AL only dining group with free seating was initiated during a period of renovations, the dining atmosphere was much improved. This temporary situation led to a permanent change, because the management noticed the positive response and gave the residents a choice to continue with this arrangement after renovations.

In addition to congregate dining, AL offers recreational programming that is meant to provide socialization through shared activities. I will address the social connection component of programming in the following section, but the point I wish to make here is that the variety of choice in activities seemed limited and age-stereotyped. Like other AL researchers have found (Dobbs et al. 2008; Jungers, 2010) bingo, singsongs, knitting and chair exercises are associated with a particular image of the interests or abilities of older adults, rather than actual preferences. As the baby boomers age, will AL facilities continue to lean toward these types of classes when older adults are more likely to be familiar with picking up computer tablets or gym weights than knitting needles?

Finally, participant narratives demonstrated that, across all the above domains, they did not just want *some* choice – playing bingo or playing bridge; showering on Monday or showering on Wednesday –they wanted *meaningful* choices. What was considered meaningful, however, was determined by participants according to their personalities and life histories. Being able to make choices that were consistent with lifelong patterns and values created a sense of continuity despite change. Continuity theory is a helpful way of understanding how older adults attempt to maintain a sense of consistency of self over time. Instead of positioning older adulthood as a discrete developmental phase of life, it offers a link to a person's earlier life stages and other changes he or she may have experienced (Grenier, 2012). Continuity is both internal, in terms of holding a "consistent framework of ideas" about the self and the world, as well as external, in terms of consistent social roles, activities and relationships (Atchley, 1999, p. 9). The theory positions individuals as active agents and "presumes that individual choices are made not only to achieve goals but to adapt to constantly changing circumstances, as the individual sees them" (Atchley, 1999, p. 6). Importantly, continuity theory "does not predict that using a continuity strategy for decision making will lead to successful adaptation; it simply predicts that most people will try continuity as their first adaptive strategy" (Atchley, 1999, p. 7). Grenier (2012) also notes that episodes of illness or impairment, such as those that influenced my participants' decisions to relocate to AL, might challenge a person's sense of continuity. Older people make efforts to maintain continuity despite these challenges, including attempts to adapt preferred activities to their new level of ability. Where adaptation is no longer possible or when individuals cannot reframe their thinking, this discontinuity often causes tension or a sense of liminality (Grenier, 2012, p.141), as in Ian's narrative.

Previous research has shown that in AL, maintaining continuity of self is an ongoing, multilevel endeavour that is influenced by structural as well as interpersonal, psychological, material and cultural factors, and that having a greater degree of choice and expression in these areas contributes to a greater sense of satisfaction with life in that environment (Perkins, Ball, Whittington & Hollingsworth, 2012). The current study supports these findings. For example, when Rose was given the choice to join the Food and Operations Committees, she felt satisfied because she was finally able to replicate the structural involvement she previously enjoyed at her community centre. What this suggests is that 'activities' offered in AL need not be limited to organized or leisure-type programs. Indeed, participant narratives in this study demonstrated that even activities that might be considered 'chores' such as cooking or cleaning can be personally meaningful, a finding which is echoed other research (Frank, 2001; Williams & Warren, 2008).

To summarize, meaningful choice and the avenues for it are important factors in how participants in this study experienced relocation. These findings support the existing research, but also draw attention to the importance of opening up a space within AL for residents themselves to suggest what is meaningful, according to personal values and life histories. Choice is intertwined with other AL values such as independence, autonomy, dignity and respect, so increasing opportunities for meaningful choice could therefore have positive effects on residents' overall feelings of continuity and being settled.

8.1.2 Connection

In the discourse of the AL documents I analyzed, the notion of 'connection' is represented narrowly in terms of opportunity for interpersonal interaction between residents, and the route to providing it is through communal dining and recreational programming. This conceptualization does not seem to encompass the needs or expectations of the participants in

this study, however. In part, this was because they did not mention increased social interaction as a factor in their decision to relocate to AL; more important was the access to health and personal support services.

Yet, AL is a congregate-style housing environment, and so points of connection with other residents did feature in participants' relocation narratives, both positively and negatively. Although my participants had not made any close, primary friendships in AL, they still wanted or enjoyed a level of day-to-day camaraderie with other residents. However, navigating the social terrain was not always easy, even for someone as positive as Rose. Her initial dining room experience was very negative and left her feeling isolated and vulnerable. This incident is mirrored by Sussman and Dupuis (2014) in their research in a long term residential care setting; they found that the absence of welcoming rituals, including welcoming residents to the dining room for the first time, were traumatic for new residents. Rose persevered, however, and was eventually able to approximate the connections she had in her former community where she enjoyed "knowing and caring about a lot of people." Yet, this type of peer connection was elusive for Ian, who "could not get his head around" being without a friend or a partner who could at least share conversations and mutual interests. Being a social person, Ian was frustrated by the perceived lack of receptivity to, or opportunity for, companionship.

Interestingly, participant narratives also highlight how connections with other residents could be inhibited by the practice of comparing oneself with others around function and ability. This is a common theme found in the research on AL and long term residential care (Dobbs et al., 2008; Fisher, 1990; Heliker, 2006; Lee et al. 2013; Sandhu, Kemp, Ball, Burgess & Perkins, 2013). Cutchin (2013, p. 114) makes the point that when incoming residents cast other residents as "passive or resigned to dependence" upon arriving in AL, it then makes it difficult to integrate

because doing so would then question one's own level of ability or independence. Ian, for example, remained skeptical of making social connections in Forest Place even after the dining was adjusted to include AL residents only (and therefore address his complaint that he could not connect with residents at his table with cognitive impairments). Rose also demonstrated a sense of being separate from other residents when she critiqued the activity class from the point of view of an instructor rather than a participant – she could not see herself as someone who needed that basic level of activity. This is similar to findings reported by Sandhu et al. (2013), who found that structured activities targeted towards the least able seemed to contribute to an "us" and "them" attitude (p. 324).

Another type of relationship mentioned by participants, but which is not encompassed in the narrow conceptualization of 'connection' in AL policy, is the staff-resident relationship. Importantly, staff-resident relationships set the tone for participants' feelings of being valued and heard (or not). The first interaction Rose had with the Director at Forest Place assured her that her unique profile had been read and that there were caring individuals in key positions whom she could turn to. This connection with staff continued to evolve to the point where she was having one-on-one meetings with the AL manager to discuss ideas and projects. Rose was also astute in recognizing that the attitude of staff influenced the experiences of residents; she felt that in asking staff to treat residents well they must be treated well themselves. Mabel felt fond of the staff at her residence and appreciated that the manager liked to give hugs. The sense of caring she felt around her contributed directly to her feeling that her AL was a "good place to end up." On the other hand, one of Ian's first interactions with the staff at Forest Place left him feeling chastised for expressing excitement towards cooking instead of using the dining room. This seemed to establish a sense of distrust towards the "bigwigs" instead of the possibility for open

communication and self-expression. Later, he was able to feel connected to several front line care staff, which he viewed as one of his few opportunities for engaged conversation. Paying attention to organizational culture and the relationships between staff and residents is important, because staff are the physical representatives of AL policy and service regulations. Cultivating positive connections between staff and residents is fundamental to providing a positive relocation experience and also a larger sense of positive affect in the AL residence. Andrews et al. (2103) suggest that space and place are "relationally configured and performed, possessing a somatically registered energy, intensity and momentum that precedes deep cognition" (p. 1339). Ian and Rose both referenced such an affective assessment of place when discussing how they needed to step into an AL to truly get a sense of what it would be like to live there.

Additionally, participant narratives also referenced continued relationships with family and friends as being influential as they settled into AL. These relationships provided a discursive and literal thread of continuity between participants' pre- and post-relocation identities and life histories. The freedom and independence of AL supported such relationships, even if family or friends did not visit as often as hoped. Participants were able to visit at their children's homes, meet friends or family for meals in restaurants, take transit to visit them, host them in their suites, and even travel internationally for visits. Although the ability to invite guests for meals in the main dining room was offered at all the participants' residences, additional options were available for entertaining at some sites. For example, Mabel's AL had a guest suite available for short term rental and a private dining room. Having these amenities provided continuity with her previous role of hostess in her own home and the ability to maintain connection with out-of-town relations. Helen had a function room available for booking at her AL residence, and Forest Place offered the penthouse for private gatherings. Moreover, these spaces were described as positive

assets regardless of how often participants actually used them, suggesting that operators move toward providing them across more sites.

Linked to the above points around welcoming rituals or providing spaces to socialize with guests, a narrow focus on peer-to-peer relationships in AL policy also does not recognize factors that participants highlighted as influential in their ability to make or maintain connections, and which influenced their feelings of being settled once there. In particular, the affective environment, the physical environment, and opportunities for structural-level involvement could be either barriers or supports. As a positive example, the neighbourhoods around residences were seen as important amenities on two levels. First, neighbourhood shops, transportation and services supported autonomy in the new environment through activities such as banking and grocery shopping. Second, neighbourhoods provided opportunities for self-directed social engagement and community participation via coffee shops, community centres, restaurants and even public benches. Ian, in particular, found enjoyment in talking to people in his neighbourhood and, although much of it had changed, the neighborhood offered a link to his earlier life. On the other hand, Rose's narrative demonstrated how the aesthetic and physical environment within AL could inhibit naturalistic opportunities for connection. Rose did not feel comfortable socializing in the common areas of the AL and had stopped attending the afternoon tea because of environmental impediments such as loud music, lack of space that was private enough to be able to talk, and immobile furniture that forced residents to sit in a prescribed way. Her experience is reflected in other studies that demonstrate how the functionality of common spaces improves social interaction (Kemp, Ball, Hollingsworth & Perkins, 2012), and suggests considering the perspective of the older adult users in terms of how the space will be viewed and used.

The work of Cutchin (2003, 2013) explores the idea of place integration in relation to older adults in AL: “Places are holistic, dynamic, and meaningful entities with histories and evolutionary trajectories with which we have intimate relationships” (Cutchin, 2013, p. 110). As such, the concept of connection can encompass the relationship an older adult has with the AL residence as a whole; a place that does not start out as being ‘home’, but which has the potential to provide a sense of “at-homeness” (Cuchin, 2013). A key idea in place integration is that new residents need to be supported to create a positive relationship with the new environment, which involves social connection, but also involves experiencing the AL as a place of opportunity and ongoing personal growth. This is not a unidirectional process – the resident has to be able to shift his or her thinking to fit the new scenario, but the AL must also offer meaningful engagement and support (Cutchin, 2013). Participant narratives in this study showed limited examples of how residents are encouraged to have a sense of ownership or input into their AL residences.

8.1.3 Some remaining observations about AL in British Columbia

Through the course of this research, I also began to make larger structural observations about AL and its role in the spectrum of care and housing for older adults. As mentioned in the introduction, AL began gaining popularity relatively recently in British Columbia, as part of a restructuring of home and community care services. The hours of both non-medical home support and medical home care home support were reduced, three levels of intermediate residential care were removed, and at the same time the entrance eligibility for long term residential care was restricted to individuals with more complex care. AL was meant to fill the resulting gap in service. Since its uptake, there have been limited critical investigations into how AL has responded to the preferences of older adults and existing structures for their care.

On one level, my investigation into the policies, industry publications, and handbooks of AL, and my conversations with older adults seems to position AL in this province as an ambiguously 'middle' place. Conceptually, it occupies a space somewhere between one's own home and long term residential care. There are private suites furnished like independent apartments, yet they are nested within a highly regulated system of care and services. Residents enter into rental-type agreements, but are not covered under the provincial Residential Tenancy Act. Residents are encouraged to be independent on the one hand, yet conform to certain expectations and structures of congregate living on the other. Individuals must require assistance with personal or health care, but not too much. Care plans are a cornerstone of the organizational handbooks and tenancy agreements, but there seems to be an ambiguous amount of flexibility around how services are delivered. Residents are required to buy into a meal plan, but some AL suites have full kitchens. The idea of AL as a middle place is echoed in other research; the literature suggests that while AL might become "home" for some residents over time, for others it remains just "a home" (Dobbs, 2004; Williams and Warren, 2008) or an "approximation of home" (Cutchin, 2003). Where physical structures of AL such as aesthetics or architecture may mimic home, the abstract qualities of home such as place memory, social relations and life experiences take time to build (Dobbs, 2004) or may never be developed in the new environment because of obstacles to expressing selfhood or finding meaningful new pursuits/relationships (Williams & Warren, 2008). As Rose's narrative demonstrated, she felt at home within her own suite, but the larger institutional environment of Forest Place and her lack of a role within it meant she felt out of place for many months. In this sense, she was only 'half settled'; stuck in the middle ground of transition.

Yet at another level, the institutional atmosphere and the constraints it presented for participants – not only around meals and recreation, but also around issues such as risk (locking the stairwell) or how medicine is administered (Rose had to fight to self administer) – suggest that in practice, AL might actually occupy a space closer to that of long term residential care than in the middle. Specifically, in the way that it has developed in the province, AL seems to have replicated some of the same organizational imbalances of long term residential care, wherein biomedical concerns take priority over the socio-emotional environment (Rockwell, 2010). For example, findings from my research echo those from a series of satisfaction surveys of AL residents that have been conducted every two years in the Fraser Health Authority in British Columbia since 2012 (Cooke, Yamashita, Brown, Straker, and Wilkinson, 2012). The latest report (Cooke, 2016) indicates that satisfaction rates with staff relations and care and hospitality services across the 32 sites have consistently been higher than those around activities, meals and dining. To illustrate, the percentage of "Yes Always" responses in the 2016 report for domains related to the building environment, staff relations, and laundry range from the low to high eighties, whereas satisfaction with activities only ranked 56.5 and meals and dining ranked 58.4.

This survey research and my own my findings thus suggest that more critical investigation is warranted around how non-medical AL services are delivered in the province. Referring back to the service delivery frame from the document analysis, it appears that the strength of AL has been in creating generally good quality care services, such as medication management and personal support/ADL services. The difficulty seems to be related to those services that involve a level of subjective preference or that intersect with the ideological frame of AL, such as choice in meals or activities. Of note, meals and activities are also the areas which receive the least amount of coverage in regulatory documents such as the *Assisted Living*

Registrar Registrant Handbook, beyond considerations for health and safety in their provision. This emphasis on the ageing body, rather than the ageing experience, reflects the continued dominance of the discourse of ageing as simply a process of physical decline. In another sense, this research raises questions around how the AL value of 'independence' has possibly contributed to the under-development of services such as recreation, perhaps because of an assumption that residents can look after it themselves. The feminist conception of interdependence, however, challenges this approach and suggests that, at an organizational level, AL should be fostering all types of relational capacity as part of supporting independence.

Another issue appears to be the simultaneous development of private and public pay AL in the province, without widespread dissemination of the differences between the two. I did not set out to compare private pay and government subsidized AL facilities in this study, and in many ways the relocation experiences of my participants who paid privately (Mabel and Hazel) were similar to those who were subsidized (Ian and Rose), as the themes of meaningful choice and connection demonstrate. But the document analysis and some aspects of the participant narratives began to highlight some important points for consideration. For example, Ian's confusion around what services he had to pay for at Forest Place and his uncertainty about what "assisted living" actually assisted with, show a lack of public awareness about the mandate of AL generally and the two different funding streams of it. When I have spoken with social work students, family, older adults and other laypersons about my research, I have similarly noticed a general lack of knowledge regarding the public/private distinctions in AL. As I mentioned above, the advertising undertaken by private AL residences seems to have generated a public image of what all AL facilities are like.

This point also emerged during a brief interview I had with the Manager of Assisted Living for the Fraser Health Authority about the challenges she currently sees in AL (Donna Clark, personal communication, June 22, 2017). She said that currently in the province, roughly half of the AL facilities are private pay, and half are subsidized. In her opinion, the government has encouraged the growth of private ALs as a means of channelling costs away from the public system. This links with current neoliberal tactics to reduce government spending on the 'grey wave' of baby boomers. Her concern is that those who opt for private AL (which she metaphorically referred to "cruise ships") do not really understand what they are purchasing; they tend to see it as a "lifestyle choice" and may not use the services as "robustly." While private AL residences can allow a person with escalating care needs to stay, this is entirely up to the operator and the ability of an individual to pay for the extra costs. In the end, residents who either cannot pay extra or who develop dementia (making them ineligible for AL) end up back in the public system. Yet these finer points about maximum services levels appear to be masked by the marketed image of private ALs as better or more desirable than subsidized AL. So individuals like Rose and Ian would prefer to live in a private-pay AL, but cannot afford it. This suggests that there is a type of structured advantage in relocating to an AL of one's choice in this province, as has been noted in American research (Ball et al., 2009; Burge & Street, 2009).

My conversation with Clark also touched on a third structural observation, which is the discussion around delineation of care levels and services in AL. As I discussed in the document analysis, the difference between 'prescribed' and 'support' levels of care is vague and has garnered criticism. Participants in this study also expressed a sense of ambiguity about how much care they could receive before having to leave AL. Recently, the provincial Seniors Advocate made recommendations to remove the maximum number of prescribed services that

AL operators can provide (Office of the Seniors Advocate, 2015/16). The legislation passed, and Clark was part of the working group who wrote up the draft regulation. On the surface, this change appears to increase the choice available to older adults, but as she explained, it is still "totally optional" that operators choose to provide more than one. This development is interesting for several reasons. First, it is an example of how 'choice' for residents in AL is actually negotiated at higher levels. Second, it relates to my above observation that AL is perhaps structurally closer to long term residential care already, and raises questions around what exactly will distinguish AL from long term residential care if services begin to expand in AL. This was already an issue highlighted in the Ombudsman's report in 2012, when there were still just two prescribed services allowed; increasing care levels may serve to muddy the distinction further. Clark suggested that it will perhaps become divided along lines of mental status, with those individuals who do not have dementia being allowed to stay longer in AL. Third, this debate around care levels reflects the persistence of trying to 'problematize' age and to approach it from a biomedical lens. Even though AL was originally envisioned as a way to correct the imbalance between the personal/social aspects of ageing and the primacy of medical care that had occurred in nursing homes, managing the ageing body and monitoring it for levels of its decline is apparently still at the core of AL as currently provided in the provincial health care system.

8.2 Findings related to Narrative

So far, this chapter has focused on the data gained about the actual relocation process, salient aspects of moving and settling into AL, and related structural questions, but there are other insights from this study that have to do with the narrative form itself. For example, one of

the most valuable aspects of using narrative in this study was the way it highlighted emotion and humanity in the participants' accounts. It is true that I was interested in gathering information about participants' relocation, but there was much more involved in their descriptions than just facts. Through focusing on the accounts in their entirety, I was able to see participants' transitions to AL in the context of a lifetime of experiences. Considering the characters of family, staff and friends provided a partial window into the relationships that influenced participants' pathways and responses to relocation. By paying attention to the emotions expressed through words as well as pauses, tears, restless tapping of hands, or wry looks during in the interviews I was able to keep the humanity and uniqueness of each participant alive during the potentially distancing process of analysis. The extended case studies of Rose and Ian specifically allowed me to honour the complexities of their stories and present them to the readers as multi-faceted individuals.

A second valuable outcome of using participant narratives was their ability to create a sense of empathetic resonance with an audience. In particular, the creation of poems to capture Rose and Ian's moving in narratives proved to be a powerful mechanism for quickly conveying the essence of their stories and generating discussion. When reading these poems at conferences and presentations I noticed what others who employ this technique have found, which is that rather than being dismissed as "non-academic", the poems were a "valuable and powerful way to engage diverse audiences" (Miller at al., 2015, p. 416). Advocates of poetic representation of interviews argue that this exercise is actually highly academic – it questions the boundaries and assumptions of conventional research writing and "therefore should be of interest to those concerned with epistemological issues and challenges" (Richardson, 2003, p. 187). Employing transcription poetry strips away the polished, objective template typically used to convey

findings and rejects the pursuit of a singular or 'true' version of events. The account presented is in the participants' own words, and each reader offers the possibility of interpreting it slightly differently. For social constructionist and critical writers, this form of representation is a political act:

> Wherever truth is claimed, so is power; the claim to truth is also a claim to power. Once the veil of privileged truth is lifted, the opportunities for addressing how we think, who can legitimately think, and what we can think are legion (Richardson, 2003, p. 188).

Furman (2005, p.561) further argues that the process of creating poetry from interviews is comparable to the data reduction process in qualitative and quantitative research, in that it "forces the author to make decisions about what is essential."

From the audience's or reader's perspective, poetry is often more engaging than prose *because of* this stripped-down quality. It more closely mimics the way we naturally speak, with pauses and repetitions (Richardson, 2003, p. 189). The subject's voice is more accessible; it can come alive, freed of traditional grammatical machinations. Poetry also creates a particular space for exploring our embodied selves: "A poetic stance (poetry and more) always starts with the truth of raw experience, with life as lived and seen from the inside, from the role of the participant" and then "moves us to draw comparisons from our own immersions in life in relation to those of others" (Brady, 2005; p.1003). Importantly, poetry also attends to the emotional aspects of our experiences; something conventional research representations have avoided in order to attain the standard of detached objectivity. "The suppression of...feelings shapes a sociology that is lopsided – lopped off its body. How valid can the knowledge of a floating head be?" (Richardson, 1993, p.706). Poetry, on the other hand, can "move us into awe, mystery, the sublime, and related realizations by 'stirring things up in us'" (Brady, 2005;

p.1003). These emotions can be surprising and transforming – there is an element of discovery in seeing oneself or the world in a new way after reading words that 'ring true' in a poem (Faulkner, 2007, p. 230).

Poems, therefore, have a way of making the topic *matter*; the listener or reader becomes involved in the speaker's struggles or triumphs. By extension, this is why even more conventional qualitative research is so compelling – it generally includes passages in participants' own words that describe a profound experience, insight, or feeling. In regard to relocation and ageing, stories invite us to consider the older adults in our lives, perhaps even our future selves, and reflect on what would be important to us and our loved ones in a similar scenario. For example, one recent study demonstrated the positive influence that personal stories had in being able to sensitize long term residential care staff to the experiences of lesbian and gay residents, thereby reducing staff discrimination (Pelts & Galambos, 2017). The researchers found that using videotaped storytelling by lesbian and gay older adults as a training technique facilitated an intellectual and emotional connection that helped staff to feel empathy and to think about how to improve their own practice in this area. "Storytelling, when informed by theory, may be an effective method that can be used to increase awareness by communicating the human element to LTC staff across disciplines" (p. 15). If older adults' concerns and issues can be communicated to those in positions of power, personal stories then have the potential to bring about policy changes as well. For example, the documenting of personal accounts from older adults and their families in 2008 and 2009 led the Office of the BC Ombudsperson to release a series of recommendations around home support/care, assisted living and residential care to the provincial government (for example, British Columbia, 2012). Some of these were eventually implemented, such as the creation of a single provincial website for information on long term

residential care facilities. Narrative accounts are therefore valuable for the way that they can empathetically foster dialog and effect change.

In the process of this study, I also became further convinced of the specific value of *older adults'* narratives. As mentioned, the narratives of older adults offer direct insight into how to improve services meant for them, such as AL. The participants in this study seemed intrinsically oriented to this goal; they described their interest in the project as wanting to share their knowledge with other older adults and AL providers. Before our interview, Helen even conducted her own research among some peers to find why they had moved to AL, in case the information would be helpful. Yet I wondered whether there had ever been an occasion for the participants to tell their relocation narratives outside of a research project such as this. No doubt they had recounted pieces of their stories with friends and family, but what other avenues did they have for sharing their insights? What about residents who do not participate in research projects? What platform do they have to share their feelings or learning around this event? How receptive are Resident/Tenant councils to implementing changes suggested by residents? My participants' accounts suggest that fundamental changes to the structures of AL may not be possible within the current format. In the time since Keren Wilson began developing the model of AL in reaction to the "discontent" her mother felt as a nursing home resident (Wilson, 2007, p. 9), how involved have older adults been in refining or re-defining the options of care and services available to them? Rose, for example, had some very good ideas for improving AL; she is likely not the only one. Reflecting on the publications and policy documents around AL in BC that I analyzed, I realized that while some of them referenced advice from older adults in a pre-determined way (i.e. as quotes that fit the theme of an article or section or as carefully constructed marketing testimonials), older adults do not appear to have

been involved in developing the model of AL in this province (or elsewhere), nor have they been presented as experts on the experiences of moving to AL. The absence of the voices of older adults in this domain of elder care services, an industry that is literally built upon them and for them, seems striking.[6]

Second, older adults' narratives are valuable because older adult themselves are the only ones who have an inside perspective on the experience of ageing. Gerontological researchers have historically been younger (sometimes significantly younger) than those they study. It makes sense, therefore, to explore the topic of ageing in close collaboration with older adults and employing their voices and insights. I have already made this point as part of my conceptual positioning for this study. Yet, before setting out to conduct my research this was more of a statement related to my critical and ontological orientation. I repeat the assertion again here, but this time with first-hand understanding of the importance hearing and presenting older adults' experiences. The benefit is that I have learned *from*, rather than *about* older adults. Rose, for example, modelled a way of adapting to circumstances that were less than ideal. Her story has sparked my ideas around the benefit of community development and in-house volunteering. Ian's narrative demonstrated that the path from care level to care level is not always linear or permanent; it also unearthed (and challenged) my assumption that men of his generation are not interested in cooking.

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[6] Three positive exceptions around consultations for services in British Columbia are 1) the series of public consultations held by the British Columbia Ombudsperson's Office between 2008 and 2009 noted above, 2) the recently completed (but unreleased) investigation into long term residential care conducted by British Columbia's Seniors Advocate, and 3) The AL satisfaction surveys conducted by the Fraser Health Authority that I cite in section 8.1.4 of this chapter (Cooke et al., 2013; Cooke, 2016).

Moving out from considerations related just to research or service delivery, there are questions around what avenues older adults have for speaking out generally in Western society, and for presenting an alternative discourse to that of decline and dependence. Where are the places that elders speak as experts? Currently, there are very few. The work of Plummer (1995) asserts that there are mechanisms by which private stories can eventually be heard at a wider social level, and he advocates for investigations into "the ways [stories] are produced, the ways they are read, the work they perform in the wider social order, how they change, and their role in the political process" (p. 19). He proposes that personal narratives can become political by progressing "from an 'inner world' of telling stories to the self privately to an increasingly public one where the circle of discourse becomes wider and wider" (p. 126). The process moves from the initial identification of a problem or experience that has hitherto been unnamed, to the creation of language for discussing it, and out to a community of listeners who can identify themselves in the shared stories. Ultimately, the collective story moves out even farther into the social world, hopefully connecting with new audiences who can also identify with the issues presented: "It becomes part of public discourse" (p 126). At each stage, there are mechanisms of power that "open up" and "close down" the spaces available for their telling and their legitimacy (p.27), and which vary according to cultural epochs.

To illustrate, Plummer offers the example of gay and lesbian coming out stories, which have moved from a historically very private and pathologized space to one that is publically accessible through media and social discourse. While still not universally validated, gay and lesbian (and to a lesser extent, transgender) stories have avenues where they can be told in a positive and empowering way. Such stories challenge the historical discursive construction of LGBT persons 'deviant.' Similarly, the feminist movement was built upon the recognition that

the ‘personal is political’; women shared their individual stories of struggle and found that they were linked to wider social mechanisms of patriarchy and oppression. There remains a strong feminist tradition of using narrative consciousness-raising to create solidarity and to challenge dominant discourses of power. A few of many examples include Bartlett’s (2001) work on intergenerational relationship-building between adolescent girls and older women; Flaherty’s (2012) exploration of Ukrainian women’s life narratives as part of a project to help generate a shared vision for the new democracy; and the work of Young et al. (2012) whose personal narratives are shared and reflected upon in order to claim a space for Aboriginal knowing in postsecondary education and inspire other “warrior women” who work within it.

In my research, the stories of older adults’ also highlighted the link between the personal and the political. Rose and Ian’s difficulties finding meaningful ways to interact with the wider community once they relocated highlight the marginalized role that older adults have in leading, mentoring, or using their expertise. Further, their stories challenge the notion that older adults need or want to live in age-segregated environments simply to access health care; neither Ian nor Rose would have chosen to live in AL if they had been able to finance more flexible in-home services. The stress that Rose and Helen expressed around having to downsize their homes and move into AL so quickly raises the issue of how little recognition is given to the significance of the transition for those who are relocating, and the logistical difficulty of carrying it out for those with limited support. Ian’s narrative about deciding to care for his wife himself challenges gender norms and also illustrates the financial repercussions of choosing caregiving and relationships over paid labour in our current economic system.

Arguably, personal stories of ageing have not yet come together to build an alternative, “collective story” in the sense envisioned by Plummer (1995). However, there are spaces where

older adults are gathering to share their private stories and to talk about ageing in the context of their own experiences. For example, the work of Trudy Medcalf (2009) and her colleagues (Medcalf, Tostsos & Spadafora; 2013; Medcalf & Robbins; 2016) explores the benefits of elder circles in fostering connections and dialogue between older adults. Elder circles are facilitated discussion groups that are run for approximately six weeks; they "are small closed groups of older adults who meet face-to-face at regular intervals to explore and share ideas and insight related to the experience of growing old and living in old age" (Medcalf et al., 2013). Topics are not predetermined; the role of the facilitator is simply to initiate a conversation based on a few questions and then highlight themes or help participants make connections between what speakers have said. Medcalf has run groups in social housing in Ontario, in an online format, and also in conjunction with the Ottawa Public Library in the format of elder reading circles in which the discussions are based in books or other readings about age, but often expand to incorporate personal revelations about growing older. Most recently, she and her colleagues were able to gain access to a campus of care facility in Ontario and facilitate a reading circle program in-house for the more independent faction of residents.

I interviewed Medcalf briefly about these projects, and about the value of narrative sharing around experiences of ageing (Medcalf, personal communication, July 15, 2017). She said that participants tell her that they typically do not discuss 'Ageing' as a topic among friends and family, but "if someone sets up the space and intention [for a conversation on ageing to happen], it does." The feedback she has received from participants is always positive, and she says that the benefit of the connections made and the discussions generated often extends beyond the immediate program. For example, after facilitating sessions in social housing for older adults – an environment that would seem to be full of opportunities for meeting peers – participants told

her that they no longer felt alone. In the case of the elder circle held at the campus of care, participants were able to build enough rapport with each other to ask for help running errands, something that was not already established despite the other programs offered by the facility. Medcalf said, “I’ve always found that, the kinds of conversations we have in the circle don’t just stay there.” Participants talk about the ideas with family or friends afterwards (while maintaining confidentiality), and “it changes everybody’s thinking over time.” Although she has been facilitating these circles for years, Medcalf says she only knows of one other group like it, offered in the United States. Medcalf’s motivation for developing the elder circles was out of a desire to learn about ageing for her own journey, but she says that participants tell her that they, too, are still finding their own way and “learning to be old people.” Importantly, Medcalf says the elder circles bring together people who are all at different stages of ageing, so that participants engage in “collaborative learning” and mentoring.

In a slightly different form of narrative sharing, older adults also appear to benefit from groups where personal stories about life events or other themes are crafted individually and then shared among other participants. Ray (2000) conducted research on eight different life story writing groups that she developed and ran in seniors centres in Detroit and found that, as the title of her book *Beyond Nostalgia* suggests, there is more to older adults’ life stories than sentimental reminiscence. Participants felt a sense of competence as their writing skills developed, and the group dynamics encouraged personal growth. An important point emerging from the project is that not every older adult is interested in or able to process and share their stories in a group situation, but for those who are, the ability to gain perspective from one’s own and others’ experiences can create a “larger frame” from which to view life and ageing.

In a local example, the Arts Health and Seniors program was developed in collaboration between the Vancouver Board of Parks and Recreation, the Vancouver Health Authority, and researchers from the University of British Columbia (Phinney, Moody & Small, 2014). It included two storytelling groups as part of a study on the effects of providing arts programming for community-dwelling older adults: one was a group of older LGBT individuals exploring different creative writing forms, and one was a digital storytelling group. Although the themes were not necessarily organized around ageing, participants reported a sense of discovery and togetherness. Importantly, the presentations of their work to the public gave the participants the sense that their knowledge was legitimate and valued – "Through their art, people felt able to pass on experience, knowledge, and history that would otherwise remain unknown. They understood the benefits this could have for the generations to come" (Phinney et al., 2014, p. 342).

Even when not shared in a writing group, exploring life experiences through writing can be therapeutic and help to connect the personal with the political. Ryan, Bannister and Anas (2009) explored the memoirs of 13 authors with dementia and found that there appeared to be several benefits:

> Writing helps an individual not only to find clarity and empowerment, but also to project a renewed sense of self to loved ones and the greater community. Through private journaling or by writing for an audience (and eventual publication as in the authors here), individuals with dementia can express themselves, projecting new roles — expert, chronicler, teacher, advocate and organizer, and wisdom figure. (p. 151)

While dementia is not a normal part of ageing, neither is it uncommon among older adults. The relevance of this example is that it shows how publishing sends personal narrative out into the

world where it can contest the dominant discourses (i.e. of dementia, or ageing) and make meaningful connections with others. In describing their motivation for writing the memoirs, the authors unanimously stated their desire to help others feel less alone, to change how others feel about themselves after diagnosis, and to advocate for an approach to dementia grounded in personhood, not pathology.

Another example of the public narrative sharing comes from the West End Seniors Network, a nonprofit organization in Vancouver whose mission statement is "To improve the quality of life of adults 55 years of age and older by providing social, recreational, educational and supportive programs and services that foster connection and inclusion in the broader community" (http://wesn.ca/about-us/). On their webpage, the West End Seniors Network presents a series of videos called *Stories of Success* (http://wesn.ca/stories-of-success/). In these videos, older adults recount their personal stories of facing a range of issues such as depression, addiction, relocation, caregiving, surgery, abuse, widowhood, poverty, ageing, and being gay. The individuals featured are positioned positively, as experts on their area of struggle. The storytellers share their vulnerability as well as their strength; the stories are captivating because of the humanity expressed within them.

There are two important points to be made in relation to the above examples of narrative sharing. First, it appears that older adults *want* to share their stories. Forums for older adults to do so may not yet be widespread, but when they are provided, narratives offer a way to reflect on experiences, enjoy self-discovery, create camaraderie, and pass on knowledge. This aligns with the findings from my study, where participants expressed their desire to help others with their accounts. It is unfortunate that I did not have more unrestricted access to AL facilities during recruitment, because I believe that having a conversation about the project would have more

easily generated interest from people wanting to share their stories. Second, the last three examples show how storytelling about ageing can move from the private out to the level of the public. In the process, these stories challenge the discourse of ageing as a homogeneous experience of decline and dependence. There is great potential for narrative to be used by older adults to find solidarity, not only at the level of private stories, but also through building a more collective or political discourse of ageing that reaches audiences of all age groups through the narrative ability to resonate. Similarly, strategic sharing of stories about life in AL has the potential to stimulate more sustained interest from operators, policy makers and the public to improve services in the ways that are important to residents.

8.3 Recommendations and future research

> *Settings such as assisted living are, as the name suggests, for living. And living can only be worthwhile by integrating with place and continuing to become at-home.* (Cutchin, 2013, p. 121)

At the outset of this section, it is important to recognize that the participants in this study were all culturally and ethnically white, Western individuals. In part, this may reflect the confidence of culturally-dominant individuals to come forward to share their stories, but it also reflects the limitations imposed by my stipulation that participants be able to speak comfortably in English. I made this methodological choice in order to be able to move through a large amount of narrative data and remain confident that issues of translation were not altering my understanding of participants' subjective experiences. So while the in-depth case studies of Rose

and Ian do begin to hint at differences in relocation and transition experiences that speak to social locations of gender and class, I acknowledge that this emerging story needs to be augmented with the voices of ethno-culturally diverse older adults. Similarly, hearing the unique experiences of older adults who occupy positions along the gender and sexual orientation spectrum will likely further unsettle the dominant storylines about ageing or AL and offer insight into how to make services more inclusive and responsive overall. This project was just the initial step in a larger critical investigation of AL.

What the study did identify, outside of larger questions around the current structures and services of AL in BC, is that there are two areas that appear to be fundamental to improving the relocation experiences for older adults in AL at the individual site level: providing meaningful choice and connection across a variety of domains and organizational levels. Some participants seem able to find a way to create a sense of continuity with their former lives and self identities despite the challenges and changes brought by relocation to AL. Others have a harder time and may linger in a liminal state. Both groups, however, would benefit from a more concerted effort to address issues of integration and personal continuity in order to help them settle in. In this section I present several recommendations for AL in its current form which, together, address the themes of meaningful choice and connection. A summary of these recommendations is presented in Table/Figure 8.1.

8.3.1 Facilitating resident choice

My findings indicated that participants had useful insights that could improve transition to and life in AL. Residents'/Tenants' councils are the typical forum for gathering resident input, but my findings suggest that, on their own, they vary in their ability to generate lasting change. I therefore suggest that AL operators follow the example of Forest Place and create additional

opportunities for residents to express their ideas and opinions. Establishing positions for residents to sit on various organizational committees, carrying out resident-led special initiatives, or consulting residents on organizational developments and practices are ways of including resident choice at a structural level. Not only does this demonstrate a genuine respect for the wishes of residents, it harnesses the lifetime expertise of older adults and strengthens resident connection to people and place. There are some emerging examples in the literature that support this recommendation. In one study, a group of residents was empowered to make decisions on the decor of their newly-built care facility; another group was not. Members of the first group "reported increased identification with staff and fellow residents in the new home, displayed enhanced citizenship, reported improved wellbeing, and made more use of the communal space" (Knight, Haslam & Haslam, 2010, p.1393).

A second way to increase meaningful choice would be to increase the variety of activities available. Residents could be supported to initiate or even run their own programs that reflect personal interests or pursuits outside the bounds of conventional AL activities. AL operators should also consider that the structural takeover of tasks such as grocery shopping, cooking or household cleaning from the daily routines of older adults removes a whole arena of choice and self-expression from residents. Offering residents opportunities continue certain IADLs could also be considered as part of the 'activities' offered, beyond traditional classes or group functions. For individuals without full kitchens in their suites, community cooking activities or the ability to help food preparation or service might be an enjoyable activity.

This last point relates to my final recommendation around facilitating choice, which is the general need to improve options around meals. This is a complex issue, because it involves the entire housing-plus-supports funding structure for AL. Without conducting research I cannot

offer specific recommendations, except to say that some kind of graduated payment system would be more equitable for those who wish to arrange their own meals some or all of the time. In the interim, making it clear that residents are welcome to use the kitchens they have, or make alternate arrangements, would be an imperfect but supportive alternative.

8.3.2 Greater facilitation of connection

My second area of recommendation has to do with offering more deliberate and ongoing facilitation of social and place connections in AL. One way to provide this would be to increase the scope of social work in AL. In British Columbia, social workers are not assigned to one specific AL residence to provide psychosocial, emotional or instrumental support as they are in long term residential care facilities. Instead, they oversee several AL sites and deal with more administrative issues such as assessment, placement, transfers, coordination of services, and financial profiles to determine resident rates. Yet the participant narratives in this study suggest that there would be a benefit to providing emotional and psychosocial support at least in the initial phase of transition, if not longer, for some individuals. An increased presence of social workers for therapeutic purposes appears to aid resident transition, both in terms of preadmission education and post- relocation support (Fields, Koenig, & Dabelko-Schoeny, 2012). Further, research suggests a correlation between social support and a positive attitude toward personal ageing; in one study social support in AL mediated negative effects of decreasing health or function (Park, Jang, Lee, Chiriboga, Molinari, 2015). This finding indicates the usefulness of social work's strengths based approach with older adults to help them cope with relocation and the disabling health effects that may have spurred the move to AL. In particular, social workers are adept at helping individuals find resources in their environment, thereby supporting individuals to support themselves. Other approaches in social work such as narrative therapy

could help residents with negative relocation experiences to reframe events and envision a more positive resolution to their story.

I also recommend more effort to ease the transition of new residents through peer mentorship and education. For example, Cutchin (2013) suggests that the AL facilitate interactions between current and prospective residents so that current residents can share advice on what to expect and how to prepare, as well as positive examples of maintaining ties and creating new memories. Like elder circles, peer-led information groups for new or incoming residents would provide a space for learning and support. Rose's buddy system would be another way to help new residents make positive first connections with peers and place. Her model included accompaniment to the dining room, explanation of neighbourhood amenities, and being available to answer any questions. Research also supports this as a useful way of fostering connection between residents regardless of how long they have been in AL; residents in one research project created a volunteer buddy program for those who wanted to meet for coffee or be accompanied on shopping trips (Baur et al. 2013).

Literature points to other creative, low-cost ways to improve social and place connection for both new and established residents. One study in a Swedish AL found that increased dining options resulted in improved quality social interactions at meals (Nord, 2011). In that facility, residents were allowed to take meals in their rooms if they wished, but staff also encouraged residents to eat in the common room through the use of attractive china, arranging for staff members to sit with residents and facilitate positive social engagement, and respecting the seating preferences of individuals. For example, three kinds of seating were offered: assigned seating at a few tables for small groups, open seating at a large table, and individual tables for those who did not wish to eat with others but who agreed to try taking their meals in the common

area. Other ideas from the literature include a participatory action project around the resident-identified problem of social exclusion in AL (Baur, Abma, Boelsma & Woelders, 2013), and using photovoice to capture aspects of AL that supported/did not support feelings of home (Lewinson, Robinson-Dooley & Grant, 2012). The projects provide unique examples of how to involve residents in addressing structural issues and at the same time broaden the opportunities for social engagement.

Finally, I recommend that AL residences foster residents' external connections. Developers and municipal planners should be mindful of the importance of neighbourhoods around AL sites as they are important spaces for intergenerational contact as well as services that support independence. AL operators could also bring in community services and contacts; AL residents are considered independent, but may still have difficulty with mobility or other health issues that limit their ability to access the resources of the wider community. Partnerships with community groups to provide activities or create offshoot volunteer opportunities in the AL residence would establish community ties for residents new to the neighbourhood and provide continuity for those from the area. Including family members purposefully in programming or other activities could also increase the sense of place integration for residents by helping them create new memories with loved ones in the AL setting that help it feel more like a home (Dobbs, 2004, p.68). More widespread provision of guest suites and function rooms could also have the same positive affect (Yang & Stark, 2010). Currently there are no provincial requirements to provide such spaces in AL, but even in their absence Health Authorities could negotiate with potential operators to ensure that facilities like guest rooms and function rooms are included in new developments. This is one example of how, more generally, the mandate of

offering ‘social and recreational opportunities’ needs to be operationalized further in policy and regulation handbooks.

Table 8-1 Recommendations

Recommendation	Actions to Take	Examples
Increase meaningful choices	Create opportunities for input at a structural level	• Report back on suggestions made in Resident/Tenant councils • Involve residents in special projects • Create permanent resident positions on internal AL committees • Resident consultation on proposed changes • Resident input on use and decoration of public spaces
	Offer more diverse activities	• Solicit resident suggestions • Support peer-led activities • Consider non-program activities like helping in the kitchen, serving meals or light maintenance work
	Improve meal choices	• Explore options for graduated fee schedules • Openly allow residents to use in-suite kitchens • OALR to mandate incorporation of dietary preferences
Increase social and place connections	Increase scope of social work	• Involvement beyond assessment and placement to support residents in transition
	Increase dining options	• Allow natural associations, including dining alone in the dining room • Use staff to facilitate conversation
	Facilitate resident connections	• Increase diversity of activities • Employ buddy systems and peer education for new residents • Explore the use of elder circles
	Foster external connections	• Build new ALs in established neighbourhoods • Invite community groups in to offer programs • Ensure dedicated spaces and roles for family/friends to participate in the AL

8.3.3 Areas for future research

The findings from this study point to several areas of research that would be useful in further developing a critical body of knowledge on AL in British Columbia. First, the current study could be expanded by conducting research with more stakeholders. As mentioned, interviewing a more diverse range of older adults would provide a richer and more nuanced understanding of the relocation experiences and preferences of older adults from a variety of social locations. In addition, a more direct comparison between public and private relocation experiences could prove illuminating. To add further perspective, I would also like to collect data on relocation and transition from an operational and administrative point of view through interviews with AL operators, administrators, case workers, and analysis of internal AL documents. What are the challenges to fulfilling the foundational values of AL from their perspective? How do administrators and case workers envision their role in helping residents create a life in the AL environment? Do they use the discourse of AL differently than do residents?

A second area of research suggested by my findings is a more thorough investigation into the issue of kitchens, cooking and food service in AL. Dissatisfaction with food choices and the loss felt when having to relinquish cooking are common themes in research on relocating to AL, but I have not encountered any research specifically comparing experiences of having or not having a full kitchen in one's AL suite. I am curious to know the rationale for not providing them uniformly across AL sites, how residents make the decision to use them or not, and how using them does or does not conflict with the stipulation that AL residents must take meals in the dining room.

A third area of research inspired by this study is the issue of campuses of care and the tension of association between residents with cognitive impairment and those without. Campuses of care are viewed positively because they involve less disruption when individuals move across care levels. Although my findings showed that participants had empathy toward fellow residents with cognitive impairment, they still preferred to associate in groups with similar abilities and showed examples of intolerance or discomfort interacting with fellow residents with different mental capacity. This type of investigation has the potential to reveal how ageism, ableism, social citizenship and freedom of association operate within residential care.

A final research project suggested by the results of this study is a pilot study on providing an elder circle-type program for AL residents. Such a project would investigate its ability to foster social connections, as well as any positive outcomes stemming from discussions around age and ageing. Ultimately, the stories shared by residents could even be used to inform policy and service improvements in AL; to date there has been little to no input from older adults in this capacity.

8.4 Final thoughts: Settling in versus just settling

The narratives in this study captured the experiences of individuals at a particular period of time – they were able to look back at the homes and environments they had recently left and relay their initial impressions and observations as newcomers. Their stories were not simply accounts of moving furniture, however. Participants expressed biographical details, personal values, social relationships, and reflections on ageing in their narratives. They shared their perspectives on other difficult transitions in their lives, and where this move to AL fit with their

expectations for older adulthood. Within their accounts, participants made reference to the organizational policies and practices of AL in both positive and negative ways.

The narrative of AL as presented in this study is also set within the context of a particular period of time. It has not yet been two decades since the restructuring of home and health care services in British Columbia, and there have been few wide-scale analyses on how well AL is meeting the needs of older adults in the province. Since I began this research, there have already been some shifts in policy and evaluation, and it is likely that AL will continue to evolve. My findings suggest that this evolution needs to include improvements around how residents are welcomed into AL and how operators can best support residents' physical *and* social needs. In particular, there needs to be mechanisms for residents to express continuity of self-identity and to be meaningfully involved in their new environment, at the level they choose. Further, any changes to policy or practice in AL should be undertaken alongside consultation with older adults themselves, both out of respect for the service users and also because older adults can provide very useful insight based on lived experience. Ideally, committing to an ongoing dialogue between policy and practice will help residents settle into AL, not just settle for it.

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Appendices

Appendix A Recruitment Poster

UBC School of Social Work
2080 West Mall
University of British Columbia
Vancouver, B.C. V6T 1Z2
[redacted]

Providence HEALTH CARE

Vancouver CoastalHealth Research Institute
Healthier lives through discovery

INVITATION TO PARTICIPATE IN A STUDY
Settling in: Older Adults' Narratives of Relocation to Assisted Living

What is your story of moving into assisted living?

There are many older adults who live in assisted living but there is little information on the experiences of relocating and settling in. These stories are important in understanding the diverse needs and perspectives of older adults as they make the transition. This study is being conducted as part of a doctoral dissertation.

What is involved?

- One or possibly two interviews to record your story
- Up to two follow up interviews to clarify details
- The length of each interview is up to you
- Interviews will be audiotaped but your identity will remain confidential

Who can participate?

- Individuals set to move in to an assisted living residence from a private home in the near future
- Individuals who have moved to assisted living within the past twelve months
- Individuals who can speak English

For more information contact:

Co-Investigator :
Jasmyne Rockwell, PhD (c)
[redacted]

Principle Investigator:
Dr. Deborah O'Connor, RSW, PHD

Appendix B Consent form

Consent Form

Settling In: Older Adults' Narratives of Relocation to Assisted Living

Principal Investigator
Dr. Deborah O'Connor, PhD., Professor, UBC School of Social Work
[redacted]

Co-Investigator
Jasmyne Rockwell, PhD (c), UBC School of Social Work
[redacted]

Invitation

You are being invited to participate in this research study because you will soon be moving to an assisted living facility, or you have moved in within the last twelve months. We are interested in your thoughts and experiences of relocating and settling into your new home. The study involves several interviews with a researcher to record your story.

Your Participation is Voluntary

Your participation is voluntary. You have the right to refuse to participate in this study. If you decide to participate, you may still choose to withdraw from the study at any time without any negative consequences to your anonymity, confidentiality, or assisted living services.

Before you decide, it is important for you to understand what the research involves. This consent form will tell you about the study, why the research is being done, what will happen during the study, and the possible benefits and risks.

If you wish to participate in this study, you will be asked to sign this form.

Purpose

Moving to assisted living is a popular choice for older adults who want housing with supportive services, but there are few studies exploring residents' experiences of moving and settling in. This study will explore the stories of

assisted living residents to find out what the process has been like. Hearing these stories is important for understanding what is important to older adults as they relocate. This study is being conducted as part of a doctoral dissertation. The results of the study will be written into a doctoral dissertation, scholarly articles, and possible policy recommendations.

Study Procedures

- You will be asked to participate in at least 1 interview to tell your story, and up to two follow up interviews for clarification. There may be one additional interview if your relocation story takes two sessions to record, or if you are being interviewed before you move to assisted living. Each interview will be approximately 60 – 90 minutes, but you may take more or less time, as you wish.

- In the interviews, you will be asked to share your story of moving to assisted living, including how you came to the decision to move, your expectations, thoughts, impressions, and memories of moving in, and what your life is like as you settle in. You are free to refuse to answer any question and to stop the interview at any time.

- The interviews will be conducted by Jasmyne Rockwell, Co-investigator.

- The interviews will be audiotaped and transcribed word-for-word.

- You will have the opportunity to review and give feedback on the transcripts of the interviews.

- Including the optional extra sessions as discussed above, the total commitment time would be a maximum of 5 hours.

Confidentiality

- We cannot absolutely guarantee your anonymity but will do everything possible to keep your identity and contributions confidential. This will include changing all identifying information in any study reports, including your name, **unless you request your name be published by checking the statement at the bottom of the signature page of this form.*

- You will not be referred to by name during the interview

- Any other identifying information will be removed from interview transcripts and you will be assigned a pseudonym. This consent form

and the list of pseudonyms will be kept in a separate location from the transcript.

- Recordings and transcripts of the interviews will be kept in a locked filing cabinet, and will only be accessible to the Principal and Co-Investigators.

- Computers used to store study data will be password protected.

- The recordings will not be used for any additional studies. Transcripts and recordings will be stored in a secure location in the UBC School of Social Work for a period of five years. After this time, the material will be destroyed.

Potential Risks

Talking about your experience of moving to assisted living could bring up uncomfortable memories or strong emotions. You have the right to stop the interview at any time if you feel unable to continue. You also have the right to keep certain information or responses from being included the study. A list of supportive resources will be provided that includes counselling resources and social and recreational places to find support.

Potential Benefits

There are no direct benefits to participating. However, people participating in research studies sometimes report a sense of satisfaction at being able to tell their stories. In this study, your responses may be able to provide insight into aspects of moving to assisted living that you found helpful or that could be improved, which would benefit future residents, their families, and staff.

Withdrawal

You may choose to withdraw from the study at any point, without having to give a reason. The data collected up to that point will be retained, but your identity will remain anonymous.

Remuneration/Compensation

No compensation or payment is offered, but you will be provided with the transcript or audio file of the relocation story if you wish.

Contact for information about the study

For further information about this study, you may contact the researchers named above.

Contact for concerns about the rights of research participants
Any concerns or complaints regarding your treatment or rights as a participant in this project may be directed to the Research Subject Information Line in the UBC Office of Research Services at the University of British Columbia at 604-822-8598 or RSIL@ors.ubc.ca

Settling in: Older Adults' Narratives of Relocation to Assisted Living

Consent
My signature on this consent form means:

- I have read and understood the subject information and consent form
- I have had the opportunity to ask questions and have received satisfactory responses
- I understand that my participation in this study is entirely voluntary and I am free to refuse to participate or to withdraw at any time without consequence
- I understand that I am not waiving any of my legal rights as a result of signing this consent form

I will receive a copy of this form for my own records.

I consent to participate in this study.

Signature	
Printed Name	
Date	

OPTIONAL

☐ I request that my full name be used in this research

Signature _____

Appendix C Interview guide

1) First interview

Opening questions to build rapport and ease participant into the interview:

- How long have you lived here?
- Where are you from originally?
- Questions about photographs or surroundings if in the participant's apartment.
- Do you have any questions for me before we begin?

Main Question:

- Tell me the story of how you came to live here, starting wherever you like.

Probes if not mentioned in participant's narrative:

- How did you come to live in assisted living and not another type of housing option?
- What was the process of selecting this place and being accepted?
- Can you tell me about the days just after you moved in?
- What did you expect it would be like? What do you think now that you are here?
- What is a typical day like for you here? How is this similar or different than before you lived here?
- Did you ever imagine you would live in a place like this?

2) Second or third interview

Questions related to previous interviews

- Since we last talked, is there anything new that you would like to tell me about your experience of moving here?
- How are you feeling about living here now? What is it like?
- If you had to make the decision over again would you still choose to move here?
- Were you given any brochures or other material about assisted living before you moved or when you moved in?
- Questions related to any texts, policies, handbooks mentioned in the previous interview(s)

3) Facility walk-through questions*

I imagine this interview to be spontaneous and driven by what the participant chooses to show me – these are questions to help generate some reflection but are not scripted or exhaustive.

- When you walk here/through the building, do you remember how you felt when you first moved in?
- What did you think when you first saw your room/this room?
- What are some of the things you like about living here? Some things you dislike?
- What do you think of the layout of the building and rooms?
- Do you use more of the services/rooms/facilities than you did when you first moved in?
- Are there spots/rooms outside of your apartment where you like to spend time? Can you show me? What do you like about this spot/room?
- What do you think of the neighbourhood and services?
- Ask for any stories/anecdotes about certain rooms
- Ask if the participant ever uses a particular space; when, how

*In the case that the participant opts not to go on an actual walk through the site, these questions will be modified but the themes and probes will be the same.

4) Final interview

Questions in this session will emerge from the data in the previous interviews and will be used to clarify or expand upon participant responses.