TABLE OF CONTENTS

TOWARD HEALTHY-AGING COMMUNITIES:
A POPULATION HEALTH APPROACH

REPORT PREPARED FOR
THE DIVISION OF AGING AND SENIORS
HEALTH CANADA

BY LINDA MACLEOD AND ASSOCIATES

1997

Our mission is to help the people of Canada maintain
and improve their health.
Health Canada

Division of Aging and Seniors
Health Canada
Address Locator: 4203A
Ottawa, ON
K1A 0K9
Tel.: (613) 952-7606
Fax: (613) 957-7627
E-Mail: seniors@inet.hwc.ca
Internet: http://www.hwc.ca/datahpsb/seniors/index.htm

Prepared for the Division of Aging and Seniors by Linda MacLeod and Associates.

The opinions expressed in this document are those of the contributors and do not necessarily reflect the official views of Health Canada.

Ce document est également disponsible en français sous le titre :
Pour une société qui vieillit en santé: Une approache axée sur l'amélioration de la santé de la population

TABLE OF CONTENTS

TITLE **PAGE**

TITLE **PAGE**

A separate description of the projects analysed for the report can be requested from the Division of Aging and Seniors, Health Canada. The descriptions of each project included in this supplementary document are available in the language in which

reports were submitted by each project team.

TOWARD HEALTHY-AGING COMMUNITIES: A POPULATION HEALTH APPROACH

EXECUTIVE SUMMARY

TABLE OF CONTENTS

Introduction:

Seniors, their families, policy makers and service providers who work with and for seniors are facing real challenges as we approach the end of the twentieth century. Seniors have never been a more visible and vital part of Canadian society. Yet at a time when the needs of seniors are escalating and their present and potential contributions to society are growing, program resources and, for many, personal financial resources are diminishing. The reliance on self-care and informal caregivers is also increasing at a time when families are smaller, more likely to be geographically separated and at a time when many adults in mid-life are facing the pressures of job loss, lower incomes and increased responsibilities for adult children who are unemployed. Community workers, advocates and policy makers are grappling with these challenges to create a practical, cost-effective vision which will enhance the quality of life and participation of seniors within healthy-aging communities.

The purpose of this report is to contribute to the development of such a vision by sharing knowledge. Using a Population Health framework, this report highlights practical learnings gained through a sample of the projects funded under the New Horizons: Partners in Aging program. The authors of this report gathered learnings from interim and final reports submitted by those involved in the projects, from tools created through some projects and in some cases from conversations with project representatives. The draft report was also presented and distributed at *Experience in Action: A National Forum for Healthy Aging*. The authors have integrated comments of forum participants into this paper, and thank all commenters for their insights. Based on this information, the authors suggest how these learnings can contribute to a practical strategy for the future which includes and builds on seniors' particular skills and wisdom. The report will focus particularly on what has been learned about the determinants of healthy aging and on the prevention of risks to healthy aging through health promotion approaches. The purpose of this synthesis is to:

- help clarify lessons learned through a sample of 96 projects funded between 1991 and 1995 through the Seniors Independence Program (SIP), Ventures in

Independence program and the New Horizons: Partners in Aging program;[1] (The projects analysed were selected from the projects funded under these programs with the assistance of national and regional Health Canada representatives. In the selection process, an attempt was made to reflect the range of projects funded.)

- encourage information sharing around practical knowledge and tools available;
- help communities continue to develop creative, effective and cost efficient approaches which build on the strengths, skills and contributions of seniors, and
- contribute to the work of policy makers as well as program workers at the federal, provincial/territorial and regional/municipal levels, in developing appropriate Population Health strategies related to later life.

What Practical Knowledge Have We Gained about the Determinants of Health?

The synthesis of learnings about health determinants revealed that there is a wide range of factors that contribute to seniors' health or put them in situations of risk. The analysis also shows that these determinants rarely exist separately. Therefore, multifaceted strategies must be found to address inter-related risk factors. Probably the most central risk factor is social isolation. This health determinant directly contributes to health problems and reduces the ability of seniors and their caregivers to access the information and help that they need. Addressing social isolation is not easy, for it is directly linked to the undervaluing of seniors in our society and a number of other conditions such as poverty, low literacy, language barriers, geographic isolation, inadequate housing, transportation problems, gender and culture can contribute to social isolation. To make the challenge even more daunting, negative social images of elderly people combined with the growing displacement of older workers and the increasing poverty of seniors deepens the social isolation experienced by people in later life by making seniors feel not needed, not valued and not able to contribute. Many of the programs that do exist to address some of the risk factors and health problems such as literacy programs, substance abuse programs or support groups for survivors of physical, sexual, emotional or financial abuse are not seen as appropriate by seniors. The projects analysed also emphasize that any

[1]The New Horizons: Partners in Aging program created April 1, 1995, integrated the Seniors Independence Program, established in 1988 and the Ventures in Independence program introduced in 1993, into a single funding program.

comprehensive approach must recognize and respond to the fact that informal caregivers experience many of the same risks as the seniors they care for.

To clarify these points, some of the specific learnings about health determinants revealed from the projects analysed are listed below.

- Poverty multiplies the risk of social isolation, lack of information and poor health particularly for seniors from minority cultures and for seniors with disabilities. Poverty communicates the message that seniors are not valued participants in society. In addition, having few resources makes it difficult for poor seniors to pay for transportation, food and other expenses often connected to programs, courses and other ways of getting involved. Thus the poverty of seniors tends to reduce their overall participation.

- Poverty is linked to education and skill disadvantages which further limit participation.

- Low income also affects the ability of family members to care for seniors.

- Social assistance reductions and program cutbacks are contributing to these problems for many seniors.

- Workplace and employment trends are also contributing to increased poverty among seniors and their informal caregivers.

- Increased financial uncertainty and cutbacks are eroding the social status, self-esteem and involvement of seniors.

- Seniors who are isolated socially are likely to have a wide range of health problems and risk factors which further limit their social support networks and often those of their informal caregivers as well.

- Transportation problems can create major barriers to social contact, recreation and active living for seniors in both urban and rural communities.

- Many seniors are isolated because they do not speak English or French, or because they have a different cultural background which may make existing programs inappropriate for them.

- People who have suffered a recent loss or change of lifestyle are often in situations of high risk.

- More seniors are living on their own.

- Illiteracy and low literacy have direct impacts on health. For example, they increase the risk of financial abuse and contribute to social isolation.

- Negative images of seniors communicate that seniors are not held in high esteem, contribute to age segregation and lead to inappropriate program and service responses to seniors.

- Many seniors have inadequate or inappropriate housing.

- Family members and service providers frequently deny or minimize drug and alcohol abuse by seniors and therefore place seniors with abuse problems at further risk.

- There are considerable gaps in knowledge among different health care providers concerning substance abuse among seniors and concerning prescription drugs and their effects on seniors.

- Single focus services which concentrate on curing acute problems rarely meet the needs of seniors and may minimize chronic care needs.

- Lack of knowledge about existing programs by seniors and their informal caregivers escalates risk.

- The majority of seniors and informal caregivers in situations of risk are women.

What Practical Knowledge Have We Gained about Health Promotion Strategies?

The lessons learned from the projects analysed on how best to respond to this long list of interrelated risk factors provide a comprehensive prescription for practical action.

- An emphasis should be placed on multifaceted wellness approaches which respond to the psychological, physical and social needs of seniors and their caregivers.

- Information and education for seniors, their families, health professionals, other service providers and community members more generally about the needs of seniors and their caregivers, risk factors they experience and programs available are essential to build healthy-aging communities.

- Such information should be delivered in a variety of ways, but an emphasis should be placed on informal information sharing such as word of mouth, church bulletins, etc..

- Programs should attempt to address both the needs and contributions of seniors and their informal caregivers.

- Free or easily accessible transportation should be built into every program for seniors.

- Programs and service delivery must be appropriate and sensitive to the strengths, wisdom and needs of low literate seniors and caregivers.

- Programs and service delivery must be appropriate and sensitive to the realities, contributions and needs of seniors and caregivers from different cultures and those who speak languages other than English or French.

- Access to accommodate differing abilities should be a part of all programs. The needs of the growing population of developmentally delayed seniors living in the community and their informal caregivers deserve particular attention.

- Peer advocacy, peer education, peer support, self-help groups and mutual aid approaches should be a central part of an effective strategy.

- Active living programs such as gardening, therapeutic dance programs, exercise programs, and walking programs can be low-cost and enjoyable ways for seniors of many ages and abilities to enhance their physical, psychological and social health.

- While seniors generally favour non-stigmatizing wellness programs for all ages, there is a need for the development of special support and treatment programs for senior survivors of elder, spouse or child abuse, literacy programs for seniors, computer skills courses for seniors and drug and alcohol abuse programs for seniors.

- Education and skills development should encourage intergenerational connections, be linked with leisure or recreational activities and focus on short sessions dealing with single, practical issues. Therefore, an effective skills development course might provide a module on how to use automated bank machines as part of a lunch and short outing which includes a small-group trip to the bank.

- Hiring a senior advocate and/or activity coordinator in seniors housing complexes and in seniors centres can increase seniors' access to a variety of programs in their community, reduce isolation and deal with problems in preventive ways, without incurring high program costs.

- Collaboration by service providers across programs helps make access to services easier for seniors, reduces duplication and can cut costs.

- Many seniors and their caregivers would benefit from outreach services. The special needs of long-distance informal caregivers and caregivers who work for pay full-time should be considered and addressed.

- Those providing programs can maximize the ability and willingness of seniors to participate in a program by choosing times and days which will be convenient, by maintaining some regular contact through phone calls rather than always insisting on personal meetings and by keeping programs flexible to respond to changing circumstances or needs.

- The use of trained volunteers in hospital and other health care institutions can increase the number and effectiveness of palliative care units.

What Implications Do These Findings Have for Future Policy and Community Approaches to Healthy-Aging Communities?

While the lists of learnings summarized above seem long, they point in a common direction, towards strategies which build on the contributions of seniors and encourage collaboration, the use of volunteer peer advocates, increased sensitivity and response to a wide range of risk factors and flexible preventive approaches that address the psychological, social and physical aspects of healthy-aging. Many of the most successful programs summarized in this report are not costly. Few projects involved the creation of an elaborate new service. Many built links between existing services, set up volunteer programs and hired a coordinator. Others bought kitchen or exercise equipment and then encouraged a range of informal programs suggested and often organized by seniors using this equipment. The need for money to cover transportation costs was a constant but usually low expense of most programs.

Besides learnings, the projects highlighted in this report also provide a wealth of tools and resources. It seems evident from this small sample that before more print and video resources are created, information should be exchanged on the wide range of resources which can be accessed or adapted from other communities.

The richness of learnings, of collaboration and of creativity evident in the projects analysed for this report form a positive base for future planning. It is the hope of the authors of this report that these insights will become a springboard for dialogue, planning and the creation of healthy-aging communities.

TABLE OF CONTENTS

I. INTRODUCTION: A TIME OF CHANGE AND CHALLENGES:

The Challenge of an Aging Society in a Time of Reduced Resources:

As a society, Canada is increasingly faced with the challenge of building on the strengths and meeting the needs of an aging society with fewer resources. Hard decisions are facing policy makers, front-line workers, health and social service professionals, seniors and their families in the light of hospital closures, shorter hospital stays, reductions in other health and social programs and growing demands on families, neighbours and friends to assume an ever-increasing role in caring for seniors and supporting seniors' self care.

At the same time, seniors have never been a more visible and vital part of our society. By the year 2011, it is projected that almost one quarter of the population will be 60 years of age or older. Seniors are living longer and "the majority of seniors are rightly described as healthy, clever, vital, dynamic and capable."[2] But the number of frail, very elderly seniors is also growing.

These trends present a daunting challenge. How can the health, well-being, participation and contribution of a growing number of people in later life stages, with very different needs, be enhanced in a time of reduced resources?

TABLE OF CONTENTS

Shifts in Policy Emphasis: A Brief Background to the New Horizons Program:

The federal government has attempted to take a responsive yet proactive role in the face of these changes. Through the New Horizons program, which was introduced in 1972, the federal government has always worked to build partnerships and innovation in order to promote the health, well-being, independence and participation of seniors. These central goals have remained constant, but there has been a shift in emphasis since 1972 to respond to the changing needs and realities of seniors.

Between 1972 and 1988, the New Horizons program, "by directing funding to seniors themselves, provided opportunities for older Canadians to initiate, organize

---

[2]Stones, Lee, "Negative Stereotypes...how long will they persist?" in Vital Aging, Bulletin published by the CLSC Rene-Cassin/University Institute of Social Gerontology of Quebec and the Foundation for Vital Aging, Vol. 3, Number 2, December, 1996.

and participate in meaningful activities of benefit to themselves and their communities."[3]

In 1988, as part of a five-year Seniors Initiative, the federal government increased the funding available under the New Horizons program so that seniors could work with a broad range of non-profit organizations and develop innovative approaches to support and enhance the independence and quality of life of seniors. The Seniors Independence Program was also introduced at that time.

In 1993, at the end of the previous five-year Initiative, the Federal Government renewed the Seniors Initiative for another five year period, along with funding. The second initiative retained the components of the first initiative and introduced the Ventures In Independence program. It also encouraged collaboration between seniors and a wider range of partners including non-profit groups, business, labour and provincial/territorial as well as municipal governments. In addition, a stronger focus was placed on vulnerable seniors, those who were at greater risk of health problems, harm or loss. Further, the renewed initiative included the goal of developing a Federal Policy on Aging to support a comprehensive agenda for action on issues of importance to seniors and an aging society.

In April, 1995, the Seniors Independence Program and Ventures in Independence were amalgamated with New Horizons to form a single funding program called New Horizons: Partners in Aging. The purpose of this amalgamation was to "foster the involvement of seniors and their partners in action to improve the health, well-being and independence of seniors in situations of risk or prevent situations which put seniors at risk."[4]

---

[3] p.3, Health Canada, "Conceptual framework: New Horizons: Partners in Aging", Ottawa, Canada, July, 1995.

[4] Ibid.

To sum up, Health Canada seniors community programs, for the past twenty-four years, have worked to promote the health, well-being, independence and participation of seniors through innovation and partnerships. Over time, the emphasis of the programs have shifted and expanded to:

- include more partners;
- focus on seniors in situations of risk but also to emphasize seniors as contributors to society;
- embrace a focus on health determinants; and
- acknowledge that within the whole life-cycle (including childhood and youth, midlife and later life), various social, biological and economic factors contribute to the health, well-being, degree of participation and the risks experienced by seniors.

II. THE PURPOSE AND APPROACH OF THIS REPORT:

TABLE OF CONTENTS

Why Is This Report Needed?

Much has been learned through the New Horizons program since its beginning in 1972. However, as outlined above, since 1972, there have been shifts in emphasis to adapt to changing knowledge. To make sense of the learnings coming out of projects which were funded at different times and therefore under different priority emphases, it is helpful to look at these findings within a common framework. This report was commissioned to start to pull together some of the more recent learnings from projects funded between 1991 and 1995 within a life-cycle/population health framework. By presenting these findings within a common framework, it is hoped that the report will:

- help clarify lessons learned;
- encourage information sharing around practical knowledge and tools available;
- help communities develop effective and cost-efficient approaches which build on the strengths, skills and contributions of seniors; and
- contribute to the work of policy makers as well as program developers at the federal, provincial/territorial and regional/municipal levels, in developing appropriate Population Health strategies related to later life issues.

The Purpose of this Report:

TABLE OF CONTENTS

The purpose of this report is to highlight practical learnings gained through the projects funded under the New Horizons: Partners in Aging program and to demonstrate how these learnings can help strengthen and inform the goals and principles of a Population Health strategic approach. The report will focus particularly on what has been learned about the determinants of healthy aging and on the prevention of risks to healthy aging through health promotion approaches. The report is intended to begin to share the information and tools needed in this time of transition.

The report will attempt to uncover how we can use learnings gained through this initiative to work more cost-efficiently and effectively by providing some preliminary and partial answers to the following key questions:

1. What are the most critical issues affecting the participation, health, well-being and risks of seniors?
2. Which health determinants are most influential in improving health and ensuring that seniors live full lives?
3. When and how can we intervene around these health determinants to maximize the benefits of intervention?
4. What approaches provide good value for shrinking dollars?
5. Based on what we've learned through the New Horizons: Partners in Aging program, what are the next steps which should be taken at the policy and at the community levels to respond effectively to the contributions, needs and realities of people in later life?

This report can serve as a starting point only. It is through the dialogue and insights that this document may stimulate that comprehensive answers to these crucial questions will emerge.

TABLE OF CONTENTS

Who is This Report For?

This report is written for the many people who have been involved in the New Horizons: Partners in Aging program and more generally for all those who work to build a society where aging is a credit, including:

- policy makers at the national, provincial/territorial and local levels;
- community-based and national seniors non-governmental organizations;
- health and social services organizations providing services to seniors;
- health and other professionals working on issues that face seniors;
- medical and other health associations;
- federal, provincial/territorial and municipal government representatives;
- researchers; and
- any other community members working to promote the meaningful participation of seniors in an aging society.

TABLE OF CONTENTS

How Was the Information for this Report Gathered?

The information included in this report was derived primarily from a sample of the projects funded between 1991 and 1996 by Health Canada under the Seniors Independence Program (SIP), the Ventures in Independence program and the New Horizons: Partners in Aging program. Ninety-six projects out of the 2,330 projects funded from April 1991 to March, 1996 were chosen through a joint endeavour by regional and national office representatives of the New Horizons: Partners in Aging program of Health Canada.

The projects were chosen to exemplify the many types of projects funded in all regions across Canada. The selection process was difficult given the breadth and number of projects funded and in no way suggests that the other 2,318 projects are less informative or excellent than those chosen. The consultants reviewed interim and final reports as well as tools produced by the projects analysed, where available. Each document was examined from a Population Health perspective. That is, the authors of this report looked for information which would clarify how different health determinants, listed on page 7 of this report affect the health of seniors. The authors of this report also looked for learnings in these projects about how health promotion strategies can best be implemented with seniors. Representatives from some of the projects were contacted by phone to add to the information gathered and to help enrich

the analysis. Because the purpose of this report is to synthesize learnings from a sample of the projects, and it is often difficult for those involved in a project to reflect on learnings while a project is in process, an emphasis was placed on projects that were completed or near completion. For this reason, the majority of projects analysed in this report were initiated between 1991 and 1995. It is the hope of the authors of this report that those involved in projects funded more recently who read this document will provide input to representatives at the Division of Aging and Seniors on how their projects build on the learnings summarized in this report. This report was also presented and distributed at *Experience in Action: A National Forum for Healthy Aging*. The authors have integrated comments and insights of forum participants into this paper.

TABLE OF CONTENTS

What this Report Does Not Do:

This report is not an evaluation report. No attempt has been made to evaluate the projects included in this analysis, although evaluation reports which exist for some of the projects have been used in preparing this report.

The reader should also be aware that, since not all projects reviewed were evaluated, some of the findings included in this synthesis represent anecdotal observations and reflections by program/project participants and some interpretative licence by the authors of this report. To select among the many learnings and findings of the 96 projects reviewed for this report, the authors chose learnings supported in almost all cases by more than one project. In the few exceptions to this rule, the subject matter of the project set it apart from the other projects, and the authors felt that the learnings of these projects would help inform and enrich the other learnings included.

III. WHAT IS A POPULATION HEALTH FRAMEWORK AND WHY WAS IT USED?

TABLE OF CONTENTS

What is a Population Health Framework?

"Population health focuses on the entire range of individual and collective factors and conditions, and the interaction among them, that determine the health and well-being of Canadians."[5] By focusing on the determinants of health, it is possible to use an evidence-based approach to identify conditions which affect health. It is also possible to build strategies based on an assessment of risk and an understanding of social as well as economic benefits. In this way, governments, professional groups and community organizations can build on past learnings and achievements to determine and act on best investments in order to influence the factors which determine health.

The definition of health adopted in the Ottawa Charter for Health Promotion will be used in this paper. This definition describes health as a "resource for everyday living... a positive concept emphasizing social and personal resources, as well as physical capacities."[6]

What are the Major Health Determinants Included in this Framework?

The following health determinants will be explored in this paper:

- income and social status;
- social support networks;
- education;
- employment and working conditions;
- social environments;
- physical environments;
- biology and genetic endowment;
- personal health practices and coping skills;
- healthy child development;

---

[5] p.5 Division of Aging and Seniors, Population Health Directorate, Health Promotion and Programs Branch, Health Canada, "Broader Determinants of Healthy Aging: A Discussion Paper", October, 1996.

[6] p.1, World Health Organization, Health and Welfare Canada and Canadian Public Health Association, Ottawa Charter of Health Promotion, Ottawa, Ontario, 1986.

- health services;
- gender; and
- culture.

This list of health determinants was developed by Health Canada, based on a list prepared by the Federal/Provincial/Territorial Advisory Committee on Population Health in 1994 and approved by the Federal/Provincial/Territorial Ministers of Health. In this report, the authors will summarize what we have learned from the projects analysed about how each determinant affects health in later life stages. The authors also will comment on what we don't know about these health determinants.

TABLE OF CONTENTS

What are the Main Health Promotion Strategies Included in this Framework?

To reflect the priority areas of Later Life adopted by Health Canada within a Population Health framework,[7] four major health promotion questions will be addressed, using learnings from the projects analysed.

- How can we best address factors leading to high risk of chronic conditions, injury and disease?

- How can we build the capacity and responsiveness of health and social systems, communities and personal support networks?

- How can we intervene to increase personal autonomy and independence?

- How can we address unresolved policy and service concerns surrounding end of life?

[7] p.7-10, Division of Aging and Seniors, Population Health Directorate, Health Promotion and Programs Branch, "Broader Determinants of Healthy Aging", Ottawa, Canada, October, 1996.

Why is This Report Organized Around a Population Health Framework?

Population Health has been a catalyst for agreement regarding a future health approach among federal/provincial/territorial governments in recent years. For example, in 1994, a document called *Strategies for Population Health: Investing in the Health of Canadians* was prepared by the Federal, Provincial and Territorial Advisory Committee on Population Health. As well, a second report, titled *Report on the Health of Canadians*, prepared by the same committee for the Meeting of Ministers of Health, in Toronto, in September, 1996, was based on a Population Health framework.

The principles of change implicit in a Population Health framework also reinforce the need for flexibility, accountability and collaboration necessary to meet the changing health needs of an increasingly diverse and aging population in a time of diminishing resources and difficult decisions. Some of the principles implicit in a Population Health approach are outlined below.

1. Change must occur on many dimensions.

A Population Health framework is built on the premise that change must not be focused only on individuals, or families, or communities, but must involve individuals, families, communities, systems (such as the health, social service, educational or justice systems and sectors such as government and voluntary sectors) and the society as a whole.

2. Change must address the many factors which contribute to the existence of high risk and its prevention.

This framework, in its grouping of health determinants recognizes the importance of both internal and external risk factors .

3. Change must help reduce inequities.

A Population Health approach explores health determinants that look at income, employment, social status, gender and access to services, as well as genetic or biological differences.

4. Effective approaches must be cross-culturally relevant.

Because the Population Health perspective is holistic in nature, it provides a source of unity from which to build creative solutions across cultures.

5. A Population Health Framework is a Community-based Approach.

A perspective which values community-based approaches is essential to make full use of local expertise and the deep roots of health care in the community. Such an approach also builds on Canada's diversity.

6. A Population Health Approach Promotes Social as well as Economic Accountability and Cost Effectiveness.

A Population Health approach looks at separate factors affecting health and looks at how best to promote factors which contribute to quality of life, wellness and participation. Such an approach facilitates the assessment of social and economic benefits as well as costs of programs by providing a wide range of factors that can be measured and potentially acted upon. Such an approach expands both the measures of health determinants and the measures of effective health promotion approaches. A broader range of measures helps support the development of social and economic accountability indicators by all stakeholders in their efforts to enhance the dignity, independence, fairness, participation and security in the lives of seniors and their caregivers across Canada. It also promotes an approach to accountability which discourages fragmentation across services and encourages a more comprehensive view of quality of life and health for both seniors and their caregivers.

7. A Population Health Approach Reaches for a Positive New Vision.

The Population Health approach explores how health can be enhanced over the life cycle and how participation of seniors can be recognized and encouraged. It challenges us all to ensure that seniors live full and enjoyable lives. It challenges us to acknowledge and use seniors' wisdom and skills to create a better quality of life for seniors and others.

TABLE OF CONTENTS

IV. WHAT HAVE WE LEARNED FROM THESE PROJECTS?

In this section of the report, major themes and learnings from the reports analysed will be summarized within the Population Health framework outlined above. Quotes and references will be cited from different projects. To help make the report more readable, these references will not be footnoted. Instead, page numbers of reports and report titles or the name of the sponsoring organization for the project will be included in the body of the report. If you would like more information on these references, brief descriptions of the projects cited are available from the Division of Aging and Seniors of Health Canada. The titles of all the documents used in the analysis for this report are listed in the Bibliography.

Please note, in many cases, the same or similar learnings came out of many projects. In an effort to make this report "reader friendly," reference is made to only one or two projects for each theme or learning included. These should be seen as examples only. The authors have attempted to highlight as many projects analysed as possible in the body of the report. However, the authors take full responsibility for any projects which were not sufficiently highlighted.

What Practical Knowledge Have We Gained about the Determinants of Health?

TABLE OF CONTENTS

A. Income and Social Status:

Learnings:

i. *Poverty multiplies the risk of social isolation, lack of information and poor health particularly for seniors from minority cultures and for seniors with disabilities. Poverty communicates the message that seniors are not valued in society.*

While income and social status were not the major focus of any of the projects analysed, the links between poverty, social isolation, lack of information and health were repeatedly mentioned. As the authors of the "Evaluation of the Cooperative Action Program" in St. John's, Newfoundland point out: "People in lower economic circumstances are often more at risk and more isolated from networks or circles of

people who know how to access information." (P.19) In St. Jérôme, Québec, a study revealed that half of the seniors living in poverty lacked social contacts or community support, and experienced feelings of uselessness, loneliness, dependence as well as depression. These feelings frequently contributed to over-use of medication. The research also revealed that 40% of poor seniors live alone. (Centre de recherche du Diocèse de St.-Jérôme, 1996, Final Report, p.6)

These links are particularly pronounced for seniors from Aboriginal and minority culture groups and for seniors with disabilities. The Native Seniors Centre in Edmonton notes that poverty is one of the main contributors to ill-health among native seniors since "many Native seniors are the victims of a lifetime of low income, sporadic employment or no employment or little opportunity to contribute to a pension plan or acquire savings. Aging then magnifies these cumulative effects." (Native Seniors Centre, 1996) This project also identified native seniors at high-risk of poor nutrition due in part to a lack of money. Windsor Community Living Support Services found that older adults with developmental disabilities who are also poor often find it particularly difficult to make life choices for themselves, prepare for retirement and become integrated into the seniors community. In most cases, these people had limited incomes throughout their adult lives and no pension plan. Even those who had family members to care for them in earlier life are likely to be disadvantaged. Once their care-giving family members are gone, they may be dependent on welfare and not all long-term care facilities will accommodate seniors with intellectual disabilities or other severe handicaps. (Windsor Community Living Support Services, 1996)

ii. *Poverty is linked to education and skill disadvantages which further limit participation of seniors.*

The Meadowcroft Housing Corporation attributed difficulties in attracting seniors onto the Wellness Committee as the result of them always having "lived in reduced circumstances, having little education and lacking skills which might give them enough confidence to undertake leadership roles." In other words, poverty and limited education frequently result in seniors being undervalued by others which leads to low self-esteem that can make seniors feel they do not have the ability to take new challenges. (Meadowcroft Tenants Association, 1995, p.18)

iii. *Low income also affects the ability of family members to care for seniors.*

Providing care to seniors places a greater burden on families with low incomes. Because so much care giving is provided by family members and generally too few social supports are in place to assist them, social inequities directly affect the quality of care received. The Sandwich Generation Needs Assessment found that all health professionals surveyed believed that social inequities such as poverty and illiteracy impact on the ability of caregivers to provide care to seniors. (Sandwich Generation Coalition, 1994) In some families, seniors' meagre incomes are relied upon by other family members to make ends meet. For example, most Aboriginal Elders live on fixed incomes. Yet an Elder's income could be needed to meet children and grandchildren's needs if that Elder is living in an extended family system with limited access to money. (Seniors' Education Centre, University of Regina, 1994)

iv. *Government and program cutbacks are increasing these problems.*

"A number of seniors find cutbacks are already causing personal hardship for them. Increases in fees and loss of subsidies for health care, prescriptions, eyeglasses, property taxes, etc., have forced many seniors on fixed incomes into financial hardship. Some are finding it hard to pay their rent or to purchase food. Some can no longer afford even subsidized transportation rates, so stay home most of the time." (Citizen Advocacy Society of Lethbridge, 1994, p.30)

v. *Workplace and employment trends are also contributing to increased poverty among seniors and their informal caregivers.*

Interruptions in income due to layoffs, forced early retirement and lower than expected pension and social security income is creating greater poverty and uncertainty of income among seniors. This problem is likely to increase in the future. (Alberta Centre for Well-Being, 1995, p.9)

vi. *Increased financial uncertainty and cutbacks are eroding the social status and self-esteem of seniors.*

Many seniors see cutbacks as a direct attack on their dignity and worth in society. The Winnipeg Women's Health Clinic Project found that older women who attempt to stay in their jobs past 55 or to re-enter the paid workworld face pressures to make way for younger workers. (Women's Health Clinic Project, 1993) One respondent to a needs assessment in Lethbridge, Alberta became very emotional, saying that old people are being pushed aside and treated unfairly. She went on to say they are being blamed for government over-spending and are fearful of what the future holds for them. She said she knows of many older seniors who are becoming deeply depressed and worried about being a burden on society. She feels that more elderly people will feel pressured to take their own lives if they continue to be treated as scapegoats. (Citizen Advocacy Society of Lethbridge, 1994, p.30) These feelings in many cases simply add to the feelings of inferiority and loss many seniors feel after retirement.

TABLE OF CONTENTS

B. **Social Support Networks:**

Learnings:

i. *Seniors who are isolated socially are likely to have a wide range of health problems and risk factors which further limit their social support networks and often those of their informal caregivers as well.*

In one study, when a registered nurse made door-to-door visits as part of an outreach effort to isolated seniors, she met seniors with a wide range of problems "including those in need of assessment, not able to care for themselves, some with confusion, forgetfulness, loneliness and isolation, poor mobility, severe limiting breathing problems, ambulatory limitations due to failing or absent vision, general illness, shyness, dependency on other tenants for meals, care and companionship, or dependency on spouse restricting involvement of the other person, depression and lastly language barrier." (Meadowcroft Tenants Association, 1995, p.5) Isolation may also place seniors at higher risk of elder abuse. (Gerontology Association of N.S., 1995, p. 21)

ii. *Just because family members live near-by, it cannot be assumed that they are providing needed social support.*

In a study done in West Prince, in P.E.I., a large number of seniors had family living nearby, but did not necessarily see them every day.

iii. *Transportation problems can create major barriers to social contact, recreation and active living for seniors in both urban and rural locations.*

A number of projects reviewed highlighted the importance of accessible transportation to the reduction of social isolation and the creation of social support networks. For example, one study done by the Partners in Action Committee found that upwards of half of the participants in the survey rarely or never went out to social events such as community functions or eating out or visiting friends. Transportation problems, poor health and/or lack of motivation were cited as contributing factors to this lack of participation. This same study found that transportation problems were particularly acute for women who didn't or weren't allowed to drive and were dependent on aging husbands to drive them to activities. Many women who had not driven earlier in their lives, even when widowed, lacked the confidence to learn to drive or could not afford a car. Transportation problems can be even more extreme for seniors living in rural areas since distances to programs and events tend to be further and there is limited or no public transportation. Lack of transportation and money are significant barriers to Aboriginal Elders in accessing services and programs. Even if participation costs are reimbursed, some Elders may not have the cash to pay up-front. (Seniors' Education Centre, University of Regina, 1994)

iv. *Demands of care-giving for seniors can result in total isolation of both caregivers and seniors who receive this care. Therefore social support networks for seniors and their caregivers are needed to reduce risk.*

A literature review and many meetings with service agencies, seniors' clubs and seniors revealed the following factors that impact on isolation of seniors: attitudinal change; disabilities; lack of suitable transportation; health problems; financial constraints; elder abuse; role changes; communication skills and relationships. (Saskatoon Council on Aging, 1995)

v. *Being house-bound can be a barrier to receiving services and educational programs that could contribute to the creation of a social network.*

A project sponsored by the St. John's Seniors Resource Centre found that those at greatest risk of not having their basic needs met are those individuals who cannot negotiate access to resources that could provide much needed support. "This inability to access help can increase stress and may result in additional physical or mental health problems." (Cooperative Action for Seniors project proposal, 1993, p.2) This same study found that factors which keep seniors housebound include: frailty or chronic illness, mental or physical disability, visual or hearing impairment, problems with literacy, poverty, geographic isolation and differing cultural backgrounds.

vi. *Many seniors are isolated because they do not speak English or French and/or have a different cultural background.*

Service providers involved in the Citizen Advocacy Society of Lethbridge estimate that between 10 and 33% of seniors are isolated because of language barriers. (Citizen Advocacy Society of Lethbridge, 1994, p.53) Senior immigrants tend to have the same physical and social problems as their non-immigrant counterparts. However, problems such as social isolation may be more acute. Many are isolated not only from the society they have moved to because of language and values, but often from their own families who adopt the values and language of their new country. The project "Les aînés et l'interculturel" in Montréal found that in Québec, 52.6% of seniors aged 65 or more do not speak French. (Association internationale francophone des aînés, Montréal Chapter, 1995, Final Report, p.3) To compound the problem of social isolation, many immigrant communities have not yet developed seniors associations. At least in Québec, only the well-established immigrant communities which have been in Canada for more than 25 years and have created community centres, leisure activities and support networks. Further, the same project found that attracting non-immigrant seniors to participate in intercultural activities is not easy. They speculate that this may be because of the novelty and difficulty of the subject, the challenge involved in reviewing one's own values, a resistance to change, the perception that seniors have already made enough efforts to help others and the preference of seniors for leisure activities rather than activities which require more effort. The Toronto Network of Senior Ethnic women found that even their Board members were reluctant to get involved in planning and running a conference because of their lack of facility in English. (Final Evaluation, 1996, p.9)

vii. *Geographic isolation, social isolation, low income and lack of access to support networks often go hand-in-hand.*

People living in rural areas and people in lower economic circumstances are more isolated not only from services but from networks or circles of people who know how to access information. (St. John's Seniors Resource Centre, 1995, Evaluation of the Cooperative Action Program, pp. 19-20)

viii. *People who have suffered a recent loss or change of lifestyle are often in situations of high risk and may need help re-building social structures in their everyday lives.*

The Partners in Action - West Prince Seniors Committee identified "inactive" seniors or seniors in situations of risk as those who had not been seen in the community in the last few months, and those who had suffered a recent loss or change in lifestyle. The New Beginnings Program, a senior-to-senior bereavement support project in Kitchener, Ontario is based on the premise that in order to heal, people who have suffered the death of a spouse, partner, close friend or relative need a range of one-on-one and group activities to draw them back into the community. "It is critical for the vulnerable person to feel welcome and wanted in a supportive environment so as to facilitate the healing process." (SHARE, 1994, Progress Report, January to June 1996, pp.1-2)

ix. *There is a dramatic increase in the proportion of Canadian seniors living on their own.*

Gloria Gutman, a keynote speaker at a conference in May 1996 sponsored by the Greater Edmonton Foundation, noted that the proportion of seniors living in institutions and with their adult children has decreased and that even though more seniors are living longer, there is a dramatic increase in the proportion of Canadian seniors living alone in private households. This means that more frail, very elderly people are living on their own. (Greater Edmonton Foundation, 1996, pp.3-10)

TABLE OF CONTENTS

C. **Education:**

Learnings:

i. *Illiteracy and low literacy are important factors with direct impacts on seniors' health.*

Statistics Canada figures indicate that 65% of Canadians aged 55 to 69 have significant difficulty reading everyday materials. Approximately 36% cannot read or "can use printed materials only for limited purposes such as finding a familiar word in a simple text." (Statistics Canada, 1990, cited in Calgary Seniors' Literacy Society, United Way of Calgary and Area, 1995, p.5) "The low literate seniors face inordinate problems caring for their health, and managing their money. Because they rely on support networks for help with reading and writing, they are in a precarious situation where death, a transfer, or a move could leave them isolated and at-risk." (Calgary Seniors' Literacy Society, United Way of Calgary and Area, 1995, p.5)

ii. *Literacy problems contribute to the risk of financial abuse.*

The GOAL literacy project in Renfrew County found that illiteracy is a leading risk factor in financial abuse. Seniors who are illiterate must rely on family members and other caregivers to fill out forms, cash cheques and otherwise manage their affairs. This degree of dependency can contribute to the risk of financial abuse. (Council on Aging for Renfrew County, 1995, Activity Report, p.22)

iii. *Regular literacy programs rarely meet the needs of seniors.*

National figures show that fewer than 2% of students in literacy programs are seniors. (One Voice Seniors Network, 1991, cited in Calgary Seniors' Literacy Society, United Way of Calgary and Area, 1992, p.5) The authors of the United Way of Calgary report suggest that this may be because most literacy programs do not take account of the special needs of seniors related to vision and hearing changes, comfortable seating, materials with larger and darker print, the need for shorter hours of instruction, the need to socialize and identify with peers and other possible complications related to ill-health, isolation, transportation problems and a life-long fear of learning. (Southeast Regional College, Whitewood District Campus, 1995) Further, this study found that seniors need literacy programs which are geared to

individual seniors' practical needs. For example, a program which helps seniors write to their grandchildren, use a bank card, write cheques, or understand a business letter, will be much more useful than one that concentrates on general reading or writing skills.

iv. *Limited education and low literacy can be a source of frustration and embarrassment which contributes to reluctance to access programs and to build social support networks.*

In a needs assessment of seniors in Lethbridge, Alberta, it was noted that more than one-half of respondents had only a primary school education. Some seniors appeared embarrassed to admit their level of education, despite the fact that their level of education was common for others in their generation. (Citizen Advocacy Society of Lethbridge, 1994, p.25)

v. *Low levels of computer literacy among seniors increase the risk of financial abuse and limit access to a variety of services.*

Two projects, one operating in Windsor, Ontario, the other in Medicine Hat, Alberta were based on the premise that computer literacy is increasingly an essential part of independence of seniors. They suggest that seniors' independence, resistance to financial manipulation and fraud as well as their self-confidence in society more generally are threatened by the increasing prevalence of electronic communication and the low level of computer literacy among seniors. Knowledge and skills related to computers were identified as a major concern in four community priority setting meetings of seniors held in southwest Ontario as early as 1985. Project participants suggested that seniors can be supported in their independence through use of on-line computer home banking, shopping services, public library use and communication with others via e-mail. However, computer courses for seniors must be adapted to their needs. For example, the projects cited above stress the importance of adapting equipment to seniors' needs. Enlarged on-screen pointers and larger computer 'mice' are important changes to the equipment to maximize use among seniors. (Centre for Seniors, Windsor, 1996 and Venier Centre Computer Club, 1994)

vi. *Life-long learning is important to reduce withdrawal of seniors from new experiences or challenges and thereby increase participation.*

Seniors for Personal Development and Independence, sponsored by the Roadside Senior Citizens' Club in Summerville and Bonavista Bay, Newfoundland, found that helping seniors become volunteer tutors not only reduced the isolation and increased the self-esteem and skills of those seniors directly involved, but also communicated the powerful message that "you are never too old to learn something new and that there are many ways to learn." (Quoted from a sheet accompanying a proposal of the Roadside Seniors Club-Summerville)

vii. *An emphasis on life-long learning can also enhance a positive image of seniors with their wealth of experiential knowledge and reduce health risks associated with low social status.*

The St. John's Cooperative Action for Seniors Project used a volunteer "training" process "which was one of discussion and sharing of ideas incorporating the wealth of knowledge and experience these volunteers brought to the program. The purpose of the sessions was to enhance and build on the skills already developed over the lifetime of the volunteer seniors." (St. John's Seniors Resource Centre, 1995, Final Report, p.11) Similarly, an Aboriginal man who took part in Opportunity 45, a program to assist discouraged workers to re-enter the workforce says: "In my traditional Cree beliefs, age is a gift of great value in our community. We pass on our life's experiences. At Opportunity 45, I worked with others who felt the pain of age discrimination. We worked and shared and supported each other. We knew our journey was not over, but was about to push forward on a new path." (One Voice: The Canadian Seniors Network, 1994, p.24)

viii. *There is often a lack of educational opportunities in rural areas for seniors, their families and their formal caregivers.*

The Fort Saskatchewan Seniors Advisory Board and the Alberta Association of Gerontology found that "while awareness of gerontological issues is increasing, there is a lack of educational opportunities for seniors and their families as well as those who work with the aging population, particularly in rural areas." (Fort Saskatchewan Seniors Advisory Board and the Alberta Association on Gerontology, 1995, p.4)

TABLE OF CONTENTS

D. **Employment and Working Conditions:**

Learnings:

i. *Older workers are experiencing increasing economic uncertainty, displacement and income loss in this time of downsizing and workplace restructuring. These factors can be health risks.*

At a conference on older workers and Canada's labour force, Grant Schellenberg from the Centre for International Statistics noted that older workers are among the first to be laid off or offered retirement incentives as employers reorganize for labour market adjustments. Displaced older workers often find that jobs available require higher levels of education than they have, a different range of skills, and that full-time jobs are increasingly hard to find. Accordingly, older workers spend twice as long on unemployment insurance as younger workers, even though many still have dependent children at home, mortgage payments to make and the need to save for retirement. (One Voice: The Canadian Seniors Network, *Older Workers and Canada's Aging Labour Force: Final Report and Recommendations*, 1994)

ii. *The loss of social support networks is a risk factor associated with retirement.*

The Reaching Out project of the Canadian Labour Congress noted that there were benefits in seniors continuing to participate in organized activities and to help others. "A large part of quality of life for retired trade unionists is knowing they haven't been forgotten by their colleagues. Given the opportunity to spend their quality time doing the types of projects, campaigns and training that they enjoy and probably were not afforded during their working years, would create an enormous amount of enjoyment and satisfaction for our retired sisters and brothers." (Congress of Union Retirees - Canadian Labour Congress, 1993, Worksheet Funding Proposal, p.2)

iii. *Health risks for seniors and displaced workers (many of whom may be older workers) can be reduced by combining the needs of these two groups.*

One project in Mont-Laurier, Québec, Défi-Autonomie, a non-profit community business, tried to address simultaneously the home support needs of

seniors and the lack of employment in the region, an identified risk factor in terms of health. The project addressed at the same time the needs of low income seniors and the needs of social assistance recipients attempting to reintegrate into the workforce. To seniors it offered services at $2.50 an hour. Those who could not afford even this low rate, were offered the services for free. The program managed these reductions in rates by convincing the government to offer tax credits for home care services and transferring them directly to the care giving non-profit organization rather than to the customers. To social assistance recipients, it offered full-time employment for two years as well as 105 hours of employment orientation and job placements through local businesses. (Défi-Autonomie, 1995, Final Report, p.4)

TABLE OF CONTENTS

E. **Social Environments:**

Learnings:

i. *Our society, through the perpetuation of negative images of seniors, communicates a sense that seniors have little worth, increases prejudice toward seniors, reduces the self-esteem and involvement of seniors and thereby increases their health risks.*

For example, the media rarely present positive images of seniors. Television programs rarely show seniors who are autonomous, active and dynamic. More often, they are shown in dependent relationships or simply absent. (Fédération de l'Âge d'Or du Québec, 1995, Final Report, p.43)

ii. *Canadian society's tendency towards age segregation reduces the participation and comfort of seniors in society and therefore contributes to health risks.*

One project undertaken by the Centre de recherche du diocèse de St.-Jérôme, in Québec, mentioned the difficulties it had bridging the gap between generations. The researchers suggested that this may be because of the separation between age groups that has become institutionalized in our society, the lack of value given to seniors and an emphasis on "retirement as leisure" which encourages seniors not to become involved with the problems and issues of younger generations. (Les apports inestimables des aînés, 1996)

This segregation can contribute to fear and prejudice among seniors toward young people. As one senior who participated in the Fédération de l'Âge d'Or du Québec project remarked: "I had many prejudices against young people. I think of them as vulgar, lacking of feelings or respect for anything. But when you stop and listen to what they have to say about their own situation, it's different. It opened my eyes. I can better understand youth." (Fédération de l'Âge d'Or du Québec, 1995, Final Report, p.42)

iii. *The rapidly increasing diversity of Canadian society, without widespread efforts at cross-cultural sensitization may be contributing to the feelings of unease and uncertainty experienced by some seniors.*

Through the training sessions of the project "Les aînés et l'interculturel", seniors identified a number of issues related to immigration which contribute to the social isolation experienced by senior immigrants. Many of these issues highlight the need for education and sensitization both of immigrant seniors and of seniors and others in the receiving cultures. The issues included:

- exaggerated expectations both from immigrants and people from the receiving culture;
- uneasiness from both sides;
- deep attachment on both sides for their culture of origin;
- the influence of history, class and culture on perceptions;
- myths about immigrants;

- rejection and xenophobia from both the immigrants and members of the receiving culture;
- anxiety and worries for self and others, linked with aging. (Final report, p.9)

iv. *The way history has shaped the experiences of seniors also shapes risk factors affecting them, their health more generally and the ways they will react to programs and interventions.*

As the Citizen Advocacy Society of Lethbridge points out: "Seniors entering their mid-70's now have experienced the depression of the 1930's, two world wars, and the social circumstances typical of this time period in Canada. Their commonality of experience may lead to patterns of health and illness, and expectations regarding health care, family and aging that are quite different from the preceding generation, born at the turn of the century. In examining the needs of seniors, it is important to take into account the social context in which they have lived their lives, in order to design services and facilities that they will feel comfortable with and utilize." (Citizen Advocacy Society of Lethbridge, 1994, p.6)

v. *The decline in nursing home beds, the trend toward the geographic dispersal of extended families and the fact that people are living longer, means that there is a greater proportion of the senior population, including the frail senior population, living on their own.*

These points were alluded to under the section on Social Support Networks, but bear repeating here, because the emphasis on autonomy in our society combined with economic realities have imposed isolation on many seniors who may not want to be alone. As one senior interviewed for the Centre de recherche du Diocèse de St.Jérôme said: "Autonomy and loneliness, no thanks!" (Final report, p.6)

F. **Physical Environments:**

TABLE OF CONTENTS

Learnings:

i. *The quality of the environment and of housing in particular, is of increasing importance to the health and well-being as people get older because they spend more of their time in their homes.*

"If one is young and healthy and one's housing is not great, it does not matter as much because one does not have to be in it as long... When one is older, one spends more time in one's home, so the nature of the accommodation has more impact on the quality of life." (Lawton and Simon, 1968, cited in Greater Edmonton Foundation, 1996, p.9)

ii. *Most housing projects have not adapted to the changing characteristics of the aging tenant population.*

Gloria Gutman, a keynote speaker at a 1996 conference sponsored by the Greater Edmonton Foundation, pointed out that because a greater proportion of people who are renters are elderly people living alone, they would benefit from communal dining rooms, kitchens and meeting rooms. However, few housing projects have adapted to these needs. She said that better, more flexible housing alternatives are beginning to emerge, most commonly referred to as "supported independent living" and "assisted living." (Greater Edmonton Foundation, 1996)

iii. *Supportive housing is not an appropriate substitute for all nursing home care.*

Evelyn Shapiro, another speaker at the conference mentioned above, warned of the danger, in times of fiscal restraint, of seeing supportive housing as a substitute for nursing home care. She emphasized that supportive housing is appropriate only for seniors whose major needs are for support and personal care. They are not adequate for those who need constant supervision and nursing care.

iv. *Lack of space can erode caregiving arrangements and increase risks of abuse and neglect. This is a problem particularly for seniors who are part of low income families, including many immigrant seniors.*

Some immigrant seniors in the project completed by the Association internationale francophone des aînés, complained that the apartments they live in are so small that when the rest of the family returns from work, they feel they have to leave. Often they have nowhere else to go and end up hanging around shopping centres. The lack of space can also create tensions and intergenerational conflicts. (Association internationale francophone des aînés, 1995, p.42)

v. *Impoverished seniors particularly need ready access to support services.*

Since poverty is associated with poorer health and greater disability, low income seniors need good housing with access to supportive services in the form of appropriate technologies, in-house support elements and home care services to provide the care not available in-house. (Greater Edmonton Foundation 1996, p.16)

TABLE OF CONTENTS

G. **Biology and Genetic Endowments**

Learnings:

i. *Biological and genetic factors which predispose people to arthritis can have widespread effects on seniors' independence.*

"Arthritis is perhaps the greatest obstacle impeding seniors from achieving a dignified quality of life and ongoing independence. The pain, limitation, and/or functional incapacity, and associated depression severely affects an individual's quality of life." (The Arthritis Society, no date, preface).

TABLE OF CONTENTS

H. **Personal Health Practices and Coping Skills**

Learnings:

i. *The prevalence of low self esteem and stress among seniors reduces their coping skills and places many seniors at risk.*

Through a series of discussion groups and community meetings, seniors who are connected to the Roadside Senior Citizens Club of Summerville, Newfoundland, identified low self-esteem and stress as two issues that place them at risk.

ii. *Supervised, accessible and appropriate active living programs have considerable psychological and physical benefits for seniors of all ages and abilities.*

In the Meadowcroft housing complex, the establishment of an exercise room and equipment, supervised by the project coordinator who was a registered nurse helped many seniors to become more physically active in a safe environment. The exercise equipment was credited with helping to strengthen muscles before surgery, making recovery more successful, and some seniors who had come to rely on wheelchairs for mobility were able to walk again. At the end of the project, the exercise equipment remained available, but there was no supervision, increasing the chance of accidents and injury. (Meadowcroft Tenants Association, 1995)

iii. *Other forms of recreation particularly those geared to the interests of seniors contribute significantly to wellness, particularly for people who might otherwise be housebound or isolated.*

Many of the projects reviewed used recreation to reduce isolation and enhance quality of life. While some of these events could be seen by a casual observer as relatively trivial, the cumulative evidence shows that recreation should not be underestimated in their contribution to wellness. For example, the Meadowcroft seniors held special events such as two seniors lifestyle information fairs, two fashion shows with residents as models, a shopping extravaganza, teas with government representatives, a Christmas bazaar and craft sales. As the report states:

> "The activities were geared to keeping minds and bodies as active as possible. The interest and participation generated from these events and programs have been explosive... Numerous tenants came forward and volunteered on an ongoing basis. The quality of life within the complex, both physically and emotionally has been outstanding. Bringing people out of their suites and staying active is the key to better mental and physical health." (Meadowcroft Tenants Association, 1995, p.6)

iv. *Communal kitchens and cooking groups are non-threatening ways to teach nutrition and cooking skills, to encourage regular eating and better diets and to promote regular social contact.*

The Sandy Hill Community Health Centre in Ottawa, which serves a diverse neighbourhood with many high-risk seniors, initiated a Seniors Cooking Together project with activities such as Cooking Together Groups, a meal prepared for 60 seniors, 12 seniors' brown bag lunches and a Life Enrichment Group in which seniors gathered to socialize and share food and health promotion discussions after activities. As the centre staff hoped, the kitchen "has developed into a warm, non-threatening hub of activities where people naturally congregate." (Sandy Hill Community Health Centre, 1995, p.2)

v. *Family members frequently deny or minimize drug and alcohol abuse by seniors.*

Headlines Theatre found that "denial" of problems such as alcohol and drug abuse of loved ones was quite common. Phrases like: "Oh, it's just a little sherry that she drinks!" are used to minimize the effects of alcohol abuse among seniors. (Headlines Theatre, 1992, p.14)

vi. *Existing programs on substance abuse do not meet the needs of older women.*

Elixir, a non-profit organization working on problems of substance abuse with women, realized that programs on substance abuse do not meet the needs of older women. This organization then went on to develop a low cost alcohol and drug prevention program adapted to the experiences of older women. This program was based on small group sessions in which women shared their experiences and

problems, learned about aging and its consequences and developed personal skills to actively address the challenges of aging. (Elixir Inc., 1993)

vii. *There are considerable gaps in knowledge among different health care providers concerning substance abuse among seniors as well as prescription drugs and their effects. These gaps in knowledge are sometimes fuelled by dismissive attitudes towards seniors. Such attitudes can lead to questionable care including providing prescription drugs which may not be needed or appropriate.*

The Médic-Action study found that there is a vast gap of knowledge concerning prescription drugs and their side-effects among different health providers. They also found that health practitioners as well as seniors need to be reminded periodically of the benefits of proper management of prescription drugs. According to a study quoted in Projet Médic-Action, 45.6% of seniors in Quebec had been given a questionable prescription. (Tamblyn, 1994, cited in Projet Médic-Action, Final Report, p.6) The Elixir study found that some service providers' attitudes concerning substance abuse by seniors tended to justify the abuse. While the researchers found that service providers may deplore the situation on one hand, it is not uncommon to hear phrases such as : "Why not let them live as they please, they have so little time left" or "drinking is the only pleasure they have left." (Rathbone-McCuan et al., 1987, cited in Elixir, Final Report, p.5) The project Médic-Action also found that despite education provided to pharmacists on the use of medication notebooks, many still did not ask the senior for his or her medication note-book when filling out a prescription, even though they agreed it is an important tool for preventing unwanted drug interactions or duplications of prescriptions.

viii. *Mixing up medication or failing to take medication are the major medication use problems for seniors.*

The final report of the Association québécoise pour la défense des droits des retraités-es et pré-retraités-es, quotes studies that show that 36.8% of people surveyed did not take their medication as prescribed.

ix. *Seniors want and need information about the appropriate use of medications, the consequences of not using them properly, and possible alternatives to taking medication for such problems as stress, sleeplessness and arthritic pain.*

Seniors reported to workshop facilitators of “les Médicaments, oui! non! mais...” in the Outaouais, Quebec, their appreciation of having acquired new knowledge on the effects of medication. Many of them were also surprised to hear that mixing "natural products" which they did not consider medication, with other types of medicine could have some negative effects. They also appreciated learning about how to prepare before going to see their physicians or their pharmacists whom seniors do not tend to question.

I. **Healthy Child Development:**

TABLE OF CONTENTS

Learnings:

The projects reviewed did not include learnings about healthy child development as a health determinant for seniors.

J. **Health Services:**

Learnings:

i. *The lack of coordination of services and the lack of the understanding of seniors' needs by many service providers means that seniors' health needs are often not met.*

This problem was identified by the St. John's Seniors Resource Centre: "While resources exist in our community, a lack of communication and coordination means that many seniors do not have sufficient access to services which could appropriately meet their needs. Many of the groups that provide services in these areas also do not have a great understanding of the needs of seniors and do not take a proactive approach in seeking to help seniors." (“Cooperative Action for Seniors" Project Proposal, 1993, p.2)

ii. *Many health professionals and other service providers do not know how to deal sensitively and appropriately with illiterate and low literate seniors.*

As part of their literacy program for seniors, GOAL project staff did a number of in-service training sessions with other professionals and agencies. In a number of cases, service providers had identified literacy difficulties in their clients, but were unsure how to broach the subject or help them without offending the seniors. (Council on Aging for Renfrew County, 1995)

iii. *The medical model focus on acute care, on which many health services are based, tends to neglect chronic care needs and label seniors with chronic illness as undesirable patients.*

The Citizen Advocacy Society of Lethbridge found that physicians often lack patience, expertise and interest in dealing with the needs of seniors with chronic care needs. (Citizen Advocacy Society of Lethbridge, 1994)

iv. *People experiencing the wide range of issues which accompany various forms of traumatic loss are often unable to access existing services without multi-faceted community support programs which can reduce practical barriers and enhance self-confidence.*

Staff at the Aphasia Centre of Ottawa-Carleton found through support groups that most of these people were adjusting not only to direct difficulties caused by their loss of communication skills, but also to concern regarding welfare and recent reductions in welfare, family problems, further medical illness, the need for ongoing support and depression. They also found that "there is virtually no community-based support for persons adjusting to the traumatic loss of normal communication and coping with the restrictions this imposes on daily interactions with others... For the aphasic person, the communication barriers and loss of self-confidence prevents him or her from accessing support which might be available... Spouses and caregivers can become equally as socially isolated caring for them." (Aphasia Centre of Ottawa-Carleton, Project Proposal, no date, p.1)

v. T*he most effective programs to enhance coping skills address physical health needs, where appropriate, enhance skills and reduce social isolation of seniors at risk and their caregivers within the same program.*

The Welcome Back! project developed to support those affected by aphasia (i.e., a reduction or loss of the ability to speak and understand) and to facilitate their re-integration into society, is an excellent example of a program which addresses the multiple needs of at-risk seniors and their caregivers. Initially rehabilitation activities are undertaken to regain as much communication as possible and to build self-confidence. At the same time, support is given for both the emotional and practical adjustments needed to live with the condition. As individuals progress, other types of individualized support are put in place to meet individual needs and increase independence. These activities, in the developmental stages, might include member-driven support groups, joint activities, a drop-in program, assistance in accessing mainstream community services and use of volunteers to act as advocates or "communication ramps" for interactions with other people.

vi. *Seniors self-help and mutual aid groups can play a large role in decreasing loneliness and isolation, and participants can help connect one another with appropriate health services.*

According to the Canadian Council on Social Development, self-help and mutual aid groups can contribute to both healing and coping with adversity by: enhancing individual authority and control; achieving a sense of well-being; and helping seniors cope more effectively with chronic physical and mental health conditions and/or stressful life experiences. (Canadian Council on Social Development, no date, p.1-2)

vii. *Community support services are under-utilized by caregivers, usually because they don't know about these services. Guilt, fear of institutionalization, literacy problems or lack of transportation are also significant factors.*

The London InterCommunity Health Centre found that caregivers cite lack of awareness of services as the primary reason they do not access support services. (London InterCommunity Health Centre, 1995, Draft Handbook, p.8) The severity of the condition of the senior they are caring for seems to have little effect on the caregivers' use of services. A memory loss survey found that caregivers of those with advanced dementia were only marginally more likely to access services than those caring for seniors with greater capacity. Nine in ten (91%) said they did not know the

service was available. About 75% of these caregivers also said that the service was too distant and/or too complicated to access. (Alzheimer P.E.I., 1994, p.6)

The Sandwich Generation Coalition found that formal support services were underutilised by 70% of caregivers for one or more reasons including: lack of transportation; the services were unaffordable or unavailable; clients were not eligible for the services; the caregivers were too busy or too tired to find out about the services; they did not want to deal with a bureaucracy; they did not want a stranger in their home; they felt guilt, shame, pride or embarrassment; or they were socialized to believe they should be the sole caregiver. (Sandwich Generation Coalition, 1994) Similarly, the London InterCommunity Health Centre found that some seniors and their caregivers may not access services because of feelings of guilt and reluctance to let others help.

viii. *Similarly, while advocates can be useful to link seniors and caregivers to services, efforts must be made to address problems of fear of institutionalization, distrust of strangers, guilt and isolation in order to develop an effective advocate/senior relationship.*

The Citizen Advocacy Society of Lethbridge found that seniors expressed concerns about "being victimized by strangers, fear about being seen as needing services because it might limit their independence and worry that they might be seen as a burden to others." Further, this same project found that seniors are reluctant to complain or express their feelings because they feared consequences from either their caregivers or family members. (Citizen Advocacy Society of Lethbridge, 1995) The problems of matching and the need for time to develop a relationship between advocates and seniors was reiterated by the Generating Adult Learning project in Ontario which experienced difficulty matching tutors to students for similar reasons. (Council on Aging for Renfrew County, 1994)

K. **Gender:**

TABLE OF CONTENTS

Learnings:

i. *The majority of seniors who use services are women.*

This makes sense, since the majority of seniors are women. According to the 1991 Census, women make up 55% of the population 65-74, 60% of the population 75-84 and 70% of the population over 85. (Age and Opportunity Elder Abuse Resource Centre "Volunteer Training Program, Trainer's Manual", 1992 (revised 1994) pp.2-4. Various projects supported this fact, although income, education and age varied from project to project. For example, 80% of the immigrant seniors reached through the project "Les aînés et l'interculturel" were women. Nine in ten (89%) of the service recipients of Défi-Autonomie in Mont-Laurier, Québec were women. The Green Thumb program found that for a significant number of male participants in the program, this was the only program they were involved with.

ii. *The majority of caregivers to seniors also are women.*

The Caregivers Association of British Columbia found that almost 73% of caregivers to adults in this province are women, and that women were more likely than men to put in more than seven hours of caregiving daily. (Caregivers Association of B.C. Final Report, p.13) This same study also found that women are more likely than men to find caregiving stressful. (p.25)

iii. *Married women 55-75 also make up the greatest proportion of volunteers.*

The Hand in Hand project in Sudbury, Ontario found that volunteers are more likely to be women. Their research also reveals that volunteers and volunteer leaders especially are more likely to be married women 55-75, who have a higher education and income than average, and who see themselves as being in good health. (Aide aux Seniors Sudbury District East Home Support Program, 1996, p.44) This same profile was noted by the Projet d'Accompagnement des mourants et de leurs proches. In this project 86% of the volunteers were women, 57% were over 55 and 79% had more than a high school education. This project also found that 67% of the volunteers were unemployed and that about half had recently experienced a death in the family.

iv. *Women seniors are more likely than men to experience transportation problems.*

Transportation problems are particularly acute for women who didn't or weren't allowed to drive and were dependent on aging husbands to drive them to activities and socials. Women who don't drive and are widowed frequently lack the confidence to learn to drive or cannot afford a vehicle. (Partners in Action Committee, 1993)

v. *Women are more likely than men to link physical health problems with personal or social problems.*

The Elixir project found that women much more often than men will identify personal or social problems as the cause of their illness. (Aware Press, 1992, cited in Elixir, Final Report, Appendix 9, p.3) The Winnipeg Women's Health Clinic project on Healthy Aging for the Mature Woman points out that "the social realities of women aging can create emotional and physical difficulties that have a negative effect on health status. Older women ... tend to be impoverished and isolated, and their skills and wisdom are devalued." (Winnipeg Women's Health Clinic proposal, p.3). Further, aging women because they may be caring for others, may be unable to attend to their own health problems. (Winnipeg Women's Health Clinic project, 1993, p.40)

vi. *Men and women seniors have different central life concerns.*

Vancouver's Headlines Theatre found that many of the women who participated in workshops to develop a play made comments about being caregivers and the frustration and guilt this role entailed for them. The men involved emphasized their concerns about retirement and not being allowed to work. However both men and women expressed fear and frustration around the increased mechanization in our society.

vii. *Low value is given to aging women's health concerns by the traditional health system.*

The Winnipeg Women's Health Clinic project points out that aging women are often made to feel that they are the problem, that their social, emotional and economic concerns are not relevant to their health concerns. Older women may have difficulty finding a doctor who will help them prevent problems. This study found that the

needs of women 45-65 were given especially low value. (Women and Aging Project Community-based Needs Assessment: Final Report and Recommendations, 1993, pp. 19-20 & p. 22)

TABLE OF CONTENTS

L. **Culture:**

Learnings:

i. *The problems of senior immigrants are similar to those of non-immigrant seniors but language and cultural barriers mean that isolation is often more acute for immigrant seniors than for their non-immigrant counterparts.*

The Association internationale francophone des aînés found that many immigrant seniors are isolated not only from their new country because of language and values but over time, they become more isolated from their families as their families integrate into the new culture. They also have to live with the nostalgia for the country they left. As one Haitian senior said: "Aging is difficult. To age in a foreign country is twice as difficult." (Association internationale francophone des aînés, 1995, Rendez-vous d'automne, p.4)

ii. *Different value orientations and perceptions of health and health care can also affect risk among seniors in minority cultures.*

For example, the London InterCommunity Health Centre found that members of ethnocultural communities are more likely to turn to family, friends and cultural groups when help is needed. Therefore, strengthening the informal care network is especially important in these communities. (London InterCommunity Health Centre, 1995, Draft Handbook, p.38)

iii. Working styles must be appropriate to Aboriginal seniors.

The Saskatchewan Older Aboriginal Adults Learning Project identified that educational programming must be accessible and culturally appropriate and priorities must be set in partnership with Aboriginal Elders'. Research and methodologies must be adapted to meet the cultural and political realities of the Elders' lives. For example, the proper way to enter a community for the purpose of research and

TABLE OF CONTENTS

discussion varies among First Nations and Metis communities. The researcher/consultant must show the proper respect for the local community. (Seniors' Education Centre, University of Regina, 1994)

What Practical Knowledge Have We Gained About Health Promotion Strategies?
What Tools and Resources Have Been Produced to Help Communities?

In this section of the report, learnings on health promotion approaches are summarized, and tools developed or used by the projects reviewed for this report are listed. Whenever a tool is listed, the project it relates to is noted, and a contact address and telephone number provided.

A. How Can We Best Address Factors Leading to High Risk of Chronic Conditions, Injury or Disease?

TABLE OF CONTENTS

Overall Prevention:

Learnings:

i. *Information and education is essential to prevention. To make education most effective, programs should be community-specific and targeted at specific groups of seniors to increase the relevance of the program and to encourage appropriate distribution approaches.*

The Age Wise Program was intended to fill a gap in information available to rural seniors. "In many instances the workshops provided a catalyst whereby a senior addressed a necessary preventive measure which may have put them at future risk if neglected." (Fort Saskatchewan Seniors Advisory Board and the Alberta Association on Gerontology, 1995, p.15) The Community Links Program is a Nova Scotia wide network of "rural communities and their senior population sharing experiences and skills to meet the challenges of aging, health and rural life through community development." (Community Link Progress Report, p.6) They share information about community programs and learnings across communities through workshops, newsletters, testimonial letters and community-matching.

ii. *Information should be shared among service providers on predictors of high risk for injury and institutionalization so that programs can be designed for high risk groups.*

The Halton Seniors' Home Safety project noted that falls are a major cause of hospitalization and long term institutionalization in seniors. Between 1986 and 1990, 2,348 individuals 65 and over experienced falls, accounting for 44% of all falls in the region. 87 seniors died due to falls in this period. (Halton Seniors Home Safety Project, Advisory Committee - Oakville-Trafalgar Memorial Hospital, 1996) Also, a Canadian study of nursing home admissions identified the following predictors for institutionalization: advanced age (over 85); residence in housing for seniors; living without a spouse at home; mental impairment; recent hospital discharge; and problems with activities of daily living. (Shapiro and Tate, 1985, cited in Citizen Advocacy Society of Lethbridge, 1994)

iii. *Attention must be paid to caregiver burnout as a risk factor for institutionalization.*

The Adult Day Support Model - Teeoda Lodge sponsored by the Medicine Hat and District Victoria Order of Nurses found that caregiver "burnout" was one of the major risk factors for institutionalization. As a result they designed their multi-service program to provide practical services to both seniors and their caregivers, such as monitoring of medication and assistance with transportation, and to also offer caregiver counselling and health education. They found it essential to include seniors and caregivers in an integrated system of services designed to prevent problems and maintain health. (Victorian Order of Nurses, Medicine Hat and District, (1995)

iv. *Programs to help seniors re-integrate back into the community after many different types of health or personal crises, can reduce long-term health and support needs resulting from psychological and physical illnesses or injury linked to the crisis.*

The New Beginnings Program, a senior-to-senior bereavement support project in Kitchener, Ontario offers a range of one-on-one and group activities to help seniors in their healing, with the view of drawing them back into the community. (SHARE, 1994, Progress Report, January to June, 1996)

v. *A variety of active living programs can help prevent injuries, improve health and reduce the social isolation which contributes to chronic conditions and some disease progression.*

A dance-movement program for seniors in Ottawa-Carleton used this approach with a wide range of seniors in terms of mobility and general health. The program promoted a preventative, educational focus, strengthened self-care skills and practices and encouraged responsibility for personal health and mutual support of others. Dance-movement programs have been found to increase mobility, help maintain and sometimes increase level of activity, improve the functioning of the circulatory and respiratory systems, promote better balance and coordination, improve muscle tone and spatial orientation, all of which help prevent falls, and create meaningful psychosocial experiences which are non-threatening and fun. ("Movement for Health: Dance/Movement Therapy Programming with Seniors")

vi. *Evaluation of prevention and intervention programs can help to ensure that program goals are being met and can increase the sense of accomplishment and stimulate creative change.*

The Movement for Health project referred to above, created an evaluation manual specifically geared to community programs focussed on health promotion approaches.

Tools:

1. The Central West Seniors' Safety Committee created a *Home Safety Checklist* that provides questions to assess the safety of a home and offers tips for

improving physical safety in the kitchen, bedroom/bathroom and basement, and better security related to medications and fire hazards. The check list is available in English, Portuguese, Italian, French and Polish. A bookmark and presentation manual also were produced. Contact: The Trauma Prevention Council of Hamilton-Wentworth, 237 Barton St. E., Hamilton, Ontario, L8L 2X2, tel: (905) 528-8300, fax: (905) 525-4994.

2. VON Alberta South with its partners, created a number of resources used in its integrated day services to seniors at risk. They include: Group Sessions Program Planning; Client Outcome-Oriented Documentation Form, VON Adult Day Program Evaluation Assessment Tool, and Adult Day Program Job Descriptions. Contact: VON Alberta South, 631 Prospect Drive S.W. Medicine Hat, Alberta, T1A 4C2, tel: (403) 529-8025, fax: (403) 529-8026.

3. Weaver, Lynda: "How to do Simple Program Evaluation on Seniors Health Promotion Programs", Ottawa, 1994. This manual can be obtained at a cost of $25 by contacting Ms. Lynda Weaver at 96 Harrold Place, Ottawa, Ontario, K1Z 7N8.

4. The Women's Health Clinic in Winnipeg, through the Healthy Aging for the Mature Woman project, has created a video, information sheets and a resource manual concerning Healthy Aging for the Mature Woman. These materials can be ordered through the Women's Health Clinic, 3rd Floor, 419 Graham Avenue, Winnipeg, Manitoba, tel: (204) 947-1517, fax: (204) 943-3844.

TABLE OF CONTENTS

Chronic Conditions:

Learnings:

i. *Health education programs can improve the ability to cope with chronic disease.*

Chronic conditions such as arthritis can be debilitating and demoralizing and can significantly reduce quality of life. The Arthritis Self-Help Management Program is a six week health promotion program that helps people with arthritis assume greater control over their daily management of their condition. The program offers information, practical advice and support in a group format. The evaluation results in Manitoba and Ontario found that people who participated in the program increased the frequency of relaxation and stretching activities. They experienced improved quality of life, less pain and other symptoms and better mental health, and had some improvement in energy/fatigue levels, even though there was no change in their level of disability. (The Arthritis Society, no date, p.13)

ii. *Gardening can be used as a therapeutic tool for a variety of chronic conditions.*

An innovative project in British Columbia (Green Thumb Seniors) used gardening as a therapeutic tool to reduce social isolation of residents in long-term care facilities, to enhance self-esteem, alleviate depression, improve motor skills and cognitive skills, provide opportunities in problem solving, social interaction and communication. "Horticultural therapists analyse the patient's condition, assess his or her limitations and cognitive abilities, tailor activities to fit disabilities, set goals and gauge progress. A senior diagnosed with severe arthritis can plant bulbs and care for them; a blind gardener can grow and enjoy the fragrance and textures of herbs; wheelchair gardeners can tend the plants on the accessible light cart." As one nurse commented: "Everything in the hospital is done for them. In the garden, they do it for themselves." (The Green Thumb Program, 1996, p. 3, 5)

iii. *Placing a nurse in a seniors housing complex or in a housing complex with a high proportion of seniors helps improve the quality of life of seniors especially those with chronic conditions.*

The Wellness Committee of the Meadowcroft Tenants Association found that the addition of a nurse in their housing complex was a great asset to the community, improving the quality of life for residents. (Meadowcroft Tenants Association, 1995)

iv. *The need for outreach and planning programs directed at developmentally delayed seniors and their caregivers is a growing chronic care issue.*

The care and support of developmentally delayed seniors and their caregivers is a relatively new challenge since the developmentally delayed are now living longer, often to the later life stages, and are not likely to be in institutions. "Because of past policies and inadequate diagnosis, relationships between older parents and service providers are frequently strained and characterized by avoidance and mistrust, resulting in many parents staying outside the service system as much as possible and only accessing the minimal aid that they feel is necessary for themselves and their offspring." (Prince Edward Island Association for Community Living, 1995, p.12) This group of caregivers needs information on residential options if they need to make alternate care arrangements for their developmentally delayed adult children.

v. *In particular there is a growing need for retirement planning and programs to help developmentally delayed adults integrate into the wider seniors community.*

The Windsor Community Living Support Services found that, like the rest of the population, developmentally delayed adults are increasingly experiencing forced or early retirement. These adults may find it particularly difficult to prepare for retirement and become integrated into the wider seniors' community. They also found that many of these adults are turned down by senior citizens residences because of stigma associated with the label "retarded" even if the individual needed less physical care than the other residents. (Windsor Community Living Support Services, 1996)

Tools:

1. The Arthritis Self-Help Management Program produced a *Leader's Manual* for the six-week course offered by trained volunteers. Contact: The Arthritis Society, 250 Bloor St. E. Suite 401, Toronto, Ontario, M4W 3P2, tel: (416) 967-1414, fax: (416) 967-7171.

2. The Green Thumb Seniors project description can help others set up a therapeutic horticultural program. Contact: New Horizons Green Thumb Seniors, 1650 Fort Street, Victoria, B.C., V8R 1H9, tel: (250) 595-2313, fax: (250) 595-4137.

3. Training materials including a video, educational hands-on communication resources and training manuals, one for physicians and one for volunteer communication partners has been created for people working with individuals with chronic aphasia (a language disorder caused by brain injury which usually occurs after a stroke). These materials are available through the Aphasia Centre - North York, 53 The Links Road, North York, Ontario, M2P 1T7, tel: (416) 226-3636, fax: (416) 226-3706.

4. The Schizophrenia Society of Saskatchewan has created a guide entitled *Seeking Security - Now and in the Future: Guidelines for Estate Planning and Wills for Parents of Persons with Psychiatric Disabilities*. The guide includes advice on legal and financial aspects of providing for dependent family member's long-term care once the caregiver is unable to continue. To obtain a copy of the guide, send $8.00 to Schizophrenia Society of Saskatchewan, Box 305, Regina, Saskatchewan, S4P 3A1, tel: (306) 584-2620, fax: (306) 584-0525.

TABLE OF CONTENTS

Injury/Accidents:

Learnings:

i. *Prescription drug education programs for seniors, their caregivers and health professionals can reduce the risk of inadvertent over medication or adverse reactions to prescription drugs.*

The project Médic-Action found that after an education program, the percentage of seniors asking their pharmacist questions about their medication more than doubled, the percentage of seniors calling for help if their medication caused them some problems almost doubled, going from 36.5% to 66.6%, more seniors reported knowing where to call for help in case of problems, there was a dramatic increase in awareness of the danger of using dated medication (an increase from 12% to 64%) and more seniors became aware of the dangers of mixing prescription medication and over the counter drugs. (Projet Médic-Action, Final Report, 1995, pp.12-14)

ii. *Theatre is a popular and proven method of education with seniors around many issues including prescription drug use and other health and safety issues.*

This approach was used by the Centre d'information et de référence sur les médicaments chez les aîné(e)s, Les aîné(e)s de Jonquière. Organizers found that the humorous play created and performed by seniors turned out to be the most successful component of the rational use of medication project. Experience has shown that theatre productions must be directed by a volunteer professional to be highly successful.

Tools:

1. A medication note-book was developed for the project Médic-Action. For further information contact Association québécoise pour les droits des retraités-es et pré-retraités-es, 30 rue St-David, Magog, Québec, C.P. 293, J1X 3W8, tel: (819) 868-2342, fax: (819) 868-2342.

2. An educational model called SVP: Savoir, Vouloir, Pouvoir (Knowing, Wanting, Acting) which consists of a list of questions under each of these

headings was developed to encourage seniors to take responsibility concerning their own knowledge of the drugs prescribed to them. This tool is available through Médic-Action. (Address phone and fax numbers provided immediately above).

3. Small posters (8-1/2 X 11") on various health problems and medication, including how to deal with common health problems, e.g., headaches and constipation, without medication are also available through Médic-Action. (See above for contact information.)

4. The Canadian Seniors Packaging Advisory Council (CASPAC) produced a National Survey on Packaging Experiences (which indicated that packaging and labelling were a source of inconvenience and frustration for many seniors). They also created *Silver Market*, a presentation kit on seniors' packaging needs for the packaging industry and the *TIPS Information Program* including a video, leader's guide, participant pamphlets and promotional video on packaging tips and helpful hints for seniors and community groups. Contact: CASPAC, 2255 Sheppard Avenue E., Suite E330, Willowdale, Ontario, M2J 4Y1, tel: (416) 490-7860, fax: (416) 490-7844.

5. An Intervention Protocol for health professionals concerning appropriate medication use and prescription practices was also developed with a wide variety of service providers and is available through Médic-Action. (See address, phone and fax numbers above.)

6. The theatre component of the initiative, Les aîné(e)s de Jonquière, was broadcast on the local community cable television station. This 90 minute broadcast, which includes three sketches, each accompanied by a short interview is available on cassette. For further information contact: Les aîné(e)s de Jonquière, 3245, rue des Pensées, Jonquière, Québec, G7S 5T6, tel: (418) 548-6444, fax: (418) 548-4484.

TABLE OF CONTENTS

Abuse:

Learnings:

i. *Support groups for older women who have survived abuse are needed.*

In many communities there are support programs for women who have been abused by their husbands or partners, or who have survived childhood abuse. However, older women frequently feel uncomfortable in these programs because most participants are younger, and share concerns around children, etc., which are no longer relevant to older women. One participant in the Older Women's Long Term Survival Project emphasized the importance of support groups for older women survivors.

> "So here we are in the later stages of our life seizing what seems for some of us the last opportunity to find inner fulfilment and peace of mind... One of the main things we've discovered in our being together is the strength which can be gained from being connected to other women who are involved in a similar personal journey. Through this connection comes support and encouragement, along with ideas for change and recovery." (Older Women's Long Term Survival Project, 1995, pp.31-32)

Women in the Kingston, Ontario area also identified the need for therapeutic interventions specifically geared to the needs of "senior women survivors of sexual assault who are at risk of psychological difficulties, self-destructive behaviours, addictions and revictimization." (Kingston Sexual Assault Crisis Centre, Proposal, 1995)

ii. *More information about abuse is needed among seniors and their families, including their grandchildren and other school-aged children in the family.*

The project Seniors Educating Seniors about Elder Abuse found that there is little knowledge about elder abuse not only among seniors but among younger people in the society as well, including those families caring for seniors.

iii. *Senior survivors of elder abuse also need advocates, counsellors, transportation, adequate legal/police protection and a place to go.*

These were some of the findings of A Rural Study of Senior Women Victims of Violence. This study also pointed out that older persons who are victims of violence are less likely to stay in their homes. "They indicate that the feeling of vulnerability in their homes caused them to seek alternate living arrangements." (p.61) The study also points out that women would prefer to connect with advocates and resource people who are also older women and who are ideally linked to a non-profit organization in the community. Both the Older Women's Long-term Survival Project in Alberta and the Elder Abuse Prevention Project in Saskatchewan believe that more work is needed to address seniors who are or have been victims of abuse.

Tools:

1. *A Handbook for Older Women who have Survived Abuse* is available through the Older Women's Long-Term Survival Project, 807 6th Street S.E., Box 718, Calgary, Alberta, T2G 4V8, tel: (403) 253-2912. The cost is $5.00 plus $1.00 shipping and handling.

2. Elliot Lake Retirement Living published a *Seniors at Risk Manual: A Practical Guide to Care Providers* in 1996. This resource was co-authored by community service providers addressing a number of research questions including elder abuse, alcohol/medication abuse, mental health issues and self-neglect. For more information contact Elliot Lake Retirement Living at Algo Centre Mall, 151 Ontario Avenue, Elliot Lake, Ontario, P5A 2T2, tel: (705) 848-4911.

3. The Speakers Advocates and Group Educators for Seniors in Winnipeg project created a training manual to train individuals 55 years old and over to provide peer support to survivors of elder abuse. They can be reached through the Age and Opportunity Elder Abuse Resource Centre, 2nd Floor, 283 Portage Ave., Winnipeg, Manitoba, R3B 2B5, tel: (204) 956-6440, fax: (204) 946-5667.

4. The Haldimand-Norfolk Elder Abuse Project has created: a brochure on the abuse of older adults; an education manual entitled: "Toward an understanding ... The abuse and neglect of older adults in Haldimand-Norfolk"; a Resource Guide entitled: "How to help ... The abuse and neglect of older adults in Haldimand-Norfolk"; a comprehensive resource library (the public will be able

to borrow these materials); and an "Individual Case Data Collection Form" designed to assist in the collection of non-identifying information on abuse occurring both in the community and in long-term care facilities. Contact: Adult Mental Health Services of Haldimand-Norfolk, P.O. Box 760, 26 Main St. North, Hagersville, Ontario, N0A 1H0, tel: (905) 768-1101, fax (905) 768-5804.

5. The Elder Abuse Prevention Project at the Seniors' Education Centre, University of Regina, produced an *Elder Abuse Awareness Module* and a supplement which contains statistical information, legal responses and human resources in Saskatchewan related to the abuse of older people that is appropriate for both seniors and professionals. It is available in English and French. The original module can be purchased for $10 and $2 mailing, the supplement can be purchased for $8 and $2 mailing. For further information, contact: Seniors' Education Centre, University Extension, Gallery Building, University of Regina, Regina, Saskatchewan, S4S 0A2, tel: (306) 585-5816, fax: (306) 585-5736.

Disease:

TABLE OF CONTENTS

Learnings:

i. *More community-based programmes will be needed for people with Alzheimer's disease and other cognitive impairment diseases in the future.*

Alzheimer P.E.I. has estimated that by the year 2020, the number of Alzheimer patients will have more than doubled. Currently approximately 50% of those with the disease live in the community, and with health system cuts, it is likely that this percentage also will increase in the future. The Special Steps program piloted by the VON Halton Branch is one good example of community outreach for people with cognitive impairments. The program provides training and support to volunteers (many of whom are seniors) to offer companionship and supervised outings. It also provides in-house respite care to provide a break for caregivers and companionship and stimulation for care receivers. (Alzheimer P.E.I., 1994)

Tools:

1. The VON Halton Branch has created a training resource for volunteers providing a visiting and walking service to individuals with Alzheimer disease and other cognitive impairments. The resource which is intended for people working in the program only, is titled: *Special Steps: A Walking/Visiting Program for Persons experiencing Alzheimer and/or Related Disorders*. For further information contact: VON, Halton Branch, 2370 Speers Road, Oakville, Ontario, L6L 5M2, tel: (905) 827-8800, fax: (905) 827-3390.

B. How Can We Best Build the Capacity and Responsiveness of Health and Social Systems, Communities and Personal Support Networks?

Building the Capacity and Responsiveness of Health and Social Support Systems for Seniors

TABLE OF CONTENTS

Learnings:

i. *Provide a continuum of service options to respond to individual needs and community realities.*

In Alberta, three partners, the Community/Continuing Care Branch of Alberta Health, the Seniors Advisory Council for Alberta and the Canadian Association on Gerontology are developing models to demonstrate the viability of a continuum of care within the community network, which will address social, intellectual and spiritual needs as well as physical and medical needs. The approach attempts to give people choices concerning the programs and services they need. Six continuing care models have been developed. They include: adult family living programs in which seniors live with families and receive continuing care services in private homes, a native heritage enrichment program, a dementia care program, transitional short term care, integrated community care programs and an assisted living residence which reflects the principles of privacy, choice, individuality and independence.

ii. *Focus on the positive aspects of aging.*

Several projects found that seniors and caregivers prefer to be given a positive rather than a negative message or information. (Women's Health Clinic, *Women and*

Aging Project Community-based Needs Assessment, 1993). Most projects found that seniors want programs which recognize their interests, strengths and skills.

iii. *Increase access to programs and reduce stigmatization for seniors in rural and isolated areas by creating decentralized, mini-satellite programs.*

The Renfrew County literacy project recommends that large, rural programs be decentralized.

> "Different communities need local people to promote the program and act as resource centres in each area... Mini-satellites [of larger programs] give individuals the opportunity to experience the program in a non-threatening way as they can drop in to 'see' without actually admitting the problem." (Council on Aging in Renfrew County, 1995, p.17)

iv. *Ensure that programs are appropriate for seniors with low literacy and/or education levels.*

Several projects note the importance of designing and implementing services keeping in mind education levels and the embarrassment some seniors feel about problems with reading or writing. For example, services can offer to help seniors fill out forms. Literacy programs for seniors can be adapted to include information on health related subjects and other issues of concern to seniors. Because low literacy is such a hidden problem, the Renfrew County literacy program for seniors found it to be essential to work closely with the media, because of the "ripple effect" in which family and friends pass along information to seniors who might then contact the program. (Council on Aging for Renfrew County, 1994)

v. *Increase the number of activity and support coordinators in seniors dwellings and seniors organizations.*

The Wellness in Meadowcroft project, initiated by the tenants' association in a non-profit, low income seniors housing project and supported by the housing corporation, with funding for just one coordinator, provided a range of activities and events that drew seniors out of their apartments, helped them meet their neighbours and become more active in their community. When funding for the program ended, they lost their coordinator. One tenant angrily asked:

> "Would it not cost less to supply this service than to have people sit and vegetate and constantly go to the doctor and hospital and make many of us happier and healthier citizens? A coordinator would make it possible for even low income seniors to be comfortable in their own dwellings with the help at hand of someone they know and trust." (Meadowcroft Tenants Association, 1995, p.2)

vi. *Bring together existing programs and practitioners to create wellness/health centres which respond to medical, psychological and social support needs for all ages. In general, when possible and appropriate, create links with existing programs and then assess the need for new programs.*

Seniors who live near Nanaimo, B.C. identified the need for a wellness/health centre. They described it as a place which would help meet medical, psychological and social support needs. They thought the centre should offer medical services through a variety of health practitioners such as dieticians as well as doctors and nurses. They felt it should develop a medical directory to help connect people with other health services in the community. They saw the centre organizing workshops on preventative and alternative health care such as Reiki, kinesiology and massage. 80% of the seniors interviewed wanted the centre to be integrated for all ages. To serve seniors throughout the district, they also recommended that some outreach and satellite programs be considered. (Canadian Mental Health Association Nanaimo Branch, Evaluation Report, p.4)

The Women's Health Clinic of Winnipeg puts this model into practice. The Clinic is a community-based health care agency run by and for women of all ages. It provides medical services, counselling, health education, advocacy and training utilizing a variety of caregivers including physicians, nurses, educators, a social worker, a dietician, students and trained lay women. They are governed by a volunteer Board of Directors.

vii. *Whenever possible, encourage collaboration across programs to make access to services easier for seniors, to reduce duplication and to cut costs.*

One project found that it was important for a senior run bereavement support program to partner and continue to communicate with local funeral homes, especially those offering bereavement support. While there may have been some initial feelings

of competition, in the end cooperation and information sharing have clarified the situation and have given seniors more choices around bereavement support. (SHARE, 1994) People involved in the Newfoundland project Seniors for Personal Development and Independence, attribute much of their success to the fact that the project involves numerous system partners who provide support to the seniors involved in the project, are committed to the project and will help ensure its continuity. Some projects found that collaboration can be encouraged by responding to local interests, concerns and events. For example, the Cooperative Action for Seniors project responded to a prolonged power blackout in which some seniors were without heat and light for up to 3 days. This emergency brought together a wide variety of agencies which then stayed involved to collaborate around issues concerning seniors.

viii. *Use peer advocates.*

The Co-Operative Action for Seniors project reported that "many callers have stated how much they appreciated talking to someone of their own age who has shared similar experiences and with whom they can easily relate." (St. John's Seniors Resource Centre, 1995, Final Report, p.8) This same report found that peer advocacy also benefits the advocates. "The obvious enjoyment of many of the Peer Advocates in having a useful role was very evident. In addition, family members commented on the difference in their relatives who now had a purpose and a role to play, a reason to get up in the morning and a sense of fulfilment." (P.10)

ix. *To provide the type of multifaceted assistance favoured by seniors, it is important for service providers to look for underlying problems or needs beyond the initial expressed problem or need.*

The Senior Peer Counselling Project in Penticton, B.C., found that referrals were made most often in cases of illness or injury, loneliness and isolation, life style changes, followed by grief, issues regarding aging, depression, caregiver issues, relationship issues, stress and drug/alcohol use. However, the areas of concern were rarely mutually exclusive. For example, the death of a spouse could also trigger illness on top of existing physical frailty. The illness would probably be the presenting problem.

x. *Ensure that existing services are well-known by seniors and their families and that transportation or time barriers are explored with potential users. Innovative solutions should be found to overcome these barriers.*

To reduce the need for new services, ensure that all seniors, their caregivers and other family members are aware of the full range of services and programs available in the community. Peer advocates can be excellent catalysts to communicate this information. However, other informal communication methods can be used. It is important to keep in mind that information needs and openness to information can vary by personality type and life experience. Therefore, an individualized approach will often be most successful. For example, Frontenac-Kingston Council on Aging (1996) found that seniors with assertive personalities were more likely to access information needed. However, knowing about services is often not enough. The Caregivers' Association of British Columbia found that even though the majority of caregivers were familiar with various services, 23.2% used only one service. (Caregivers' Association of British Columbia, 1995, Survey Final Report, p.37) A project in Quebec helped to implement information centres in different regions and to train volunteers for these centres. (Projet Info 3e age) This is another approach to keep seniors informed.

xi. *Where possible, offer an outreach program to maintain a direct connection with seniors at risk.*

Through the Friendly Visitor Program in B.C., volunteers and staff keep regular contact with seniors at risk through phone calls and home visits by trained volunteers. Volunteer visitors perform a range of services including going shopping, out for a meal or tea, taking walks or short outings together, or simply showing an interest in the senior. Seniors are also invited to attend community meals. Another project in Sudbury, Ontario called Hand in Hand offered the above-noted services as well as health promotion and prevention programs to seniors living in rural areas. These services and programs were provided through adult day centres and were developed in partnership with seniors clubs in the region.

xii. *Programs should consider language used with seniors to increase comfort levels.*

For example, peer counsellors in Penticton, B.C. noted that the term "client" made them ill at ease.

xiii. *Generally, a shift from a medical and curative model towards more psycho-preventive models created through using community development approaches should be explored.*

A study by Leclerc, Lefrancois and Poulin (1992) notes that until recently policies and intervention have focused on medical and curative models to the detriment of psycho-preventive models. Medical models do not promote the personal autonomy or participation of seniors. (Elixir, Final Report, p.19)

xiv. *Create programs that are not only for seniors and therefore are not age-stigmatizing.*

The Women's Health Clinic of Winnipeg found that "although aging women are able to access seniors' services at fifty-five, this requires a willingness to identify oneself as 'a senior'. Many aging women are clearly not willing to identify themselves this way." (Women's Health Clinic, *Women and Aging Project Community-based Needs Assessment*, 1993, p.22)

xv. *Provide programmes that are practical and multifaceted.*

The St. James/Assiniboia Wellness Centre in Winnipeg, Manitoba, is a nurse-managed Wellness Centre operated out of an existing seniors centre. The activities provided include educational, fitness and social activities combined with very practical activities such as informal referral, home repair maintenance and transportation.

Tools:

1. The project Info 3e age produced a number of guides to facilitate the implementation of information centres including: an organizational guide suggesting how to develop a local team of volunteers, how to support, motivate and manage volunteers, how to publicize services and how to develop a reference guide on services for seniors. There also is a fundraising guide, a training manual for telephone intervention, practical tips on how to collect information on services offered at the local, regional or provincial levels and

reference manuals on such issues as consumers rights, death-related issues, income tax etc. For further information contact Association québécoise pour les droits des retraités-es et pré-retraités-es, 1160, St-Joseph Blvd east, Montréal, Québec, H2J lL4, tel: (514) 526-3845, fax: (514) 526-7151.

2. The Hand in Hand project produced a manual and a video in English and in French outlining how to develop rural adult day centres. Contact: Aide aux Seniors Home Support Program, P.O. Box 370, Noelville, Ontario, P0M 2N0, tel: (705) 398-2174, fax: (705) 898-3449.

3. In Mont-Laurier, Quebec, Défi-Autonomie and the CLSC (Centre local de services communautaires) developed a protocol to ensure that services offered by the two organizations were complementary. Contact: Défi-Autonomie d'Antoine Labelle, 610 de la Madone St., Mont-Laurier, Québec, J9L 1S9, tel: (819) 623-6681, fax: (819) 623-6681.

4. The Seniors Peer Matching Service in Sydney, N.S. created *The Friendly Visitor's Handbook*. This brief handbook can be ordered through the Volunteer Resource Centre, P.O. Box 1055, Sydney, Nova Scotia, B1P 6J7, tel: (902) 562-1245, fax: (902) 539-7210.

5. The Senior Peer Support Advisory Board of Western Manitoba has produced extensive resource material for a Seniors Peer Support Training Program, including a Facilitator's Manual, a Participant's Manual and a Learning Resources Manual. For more information, contact the Advisory Board at 510 Frederick St., Brandon, Manitoba, R7A 6Z2, tel. (204) 729-3838, fax: (204) 727-1610.

Building the Capacity and Responsiveness of Health and Social Systems for Informal Caregivers

TABLE OF CONTENTS

Learnings:

i. *Informal caregivers are an essential part of the health care system but need recognition and support.*

The National Advisory Council on Aging, estimates that family caregivers provide between 75% and 85% of the help received by seniors needing care in the community, and yet remain invisible and have few supports. (National Advisory Council on Aging, 1993, cited in London InterCommunity Health Centre, 1995, Draft Handbook, p.1) The needs of informal caregivers are also likely to increase given social and demographic trends, according to the P.E.I. Association for Community Living. They suggest that because of prolonged life expectancy, parents will have primary responsibility for caregiving throughout their adult and senior years, first for their children and then for their parents and grandchildren. The trend toward smaller families in the current adult population means that there will be fewer adult children to care for their aging parents. The larger proportion of female-led single parent families will create special demands and stresses on women and reduce the potential for these families to provide informal care. (P.E.I. Association for Community Living, 1995, p.9) The Sandwich Generation Coalition in P.E.I. also notes that "with hospital bed closures, continuing budgetary cutbacks and provincial health reform, sandwich generation caregivers represent a growing sector of Island society." (Sandwich Generation Coalition, 1994, p.4)

ii. *As the population ages, programs for informal caregivers must recognize that caregivers are also aging and therefore often have the range of needs of the seniors they care for.*

The P.E.I. Association for Community Living study points out that caregivers themselves are often seniors in poor health. In some cases they care for an aged spouse, dependent adult children and sometimes even a very elderly parent. One person interviewed in the study asks: "When does my mother get to retire? She is 73 years old now and is still caring for my two brothers and sister who have mental handicaps." (P.E.I. Association for Community Living, 1995, p.47)

iii. *Older caregivers often need outreach programs to make use of support services.*

The Sandwich Generation Needs Assessment found that ironically, "high-risk" caregivers, those most in need of support themselves, are least likely to have the time or inclination to participate in research to document their needs or to access support services. Some projects found that outreach is particularly important because many informal caregivers don't even self-identify as caregivers.

iv. *Caregivers need a range of support programs as well as relief programs such as day programs for seniors.*

The London InterCommunity Health Centre draft handbook states that according to one study the second most requested services for caregivers is support, after relief (Chappell, 1989, cited in London InterCommunity Health Centre, 1995, Draft Handbook, p.14) The Sandwich Generation Coalition found that almost half of the caregivers in their study were dissatisfied to some degree with the level of help they receive from other family members. (Sandwich Generation Coalition, 1994) Older caregivers may need longer periods of respite than many day programs currently provide. The Sandwich Generation Coalition found that in one needs assessment, of those surveyed, 51% wanted more time to themselves, 29% wanted more support from family members, 23% wanted more time with their own families and 20% wanted financial support for care giving. (Sandwich Generation Coalition, 1994)

Caregiver support groups, buddy systems and peer advocates can all provide helpful supports to caregivers. Further, one of the Pembroke VON Home Support Program project reports states that "the literature suggests that support programs should be designed to incorporate learning (about knowledge of the disability, community resources and coping skills), ventilation of feelings, humour and peer support (through the sharing of experiences). (Victoria Order of Nurses Home Support Program, 1995-1996, p.15) Aboriginal Elders need respite from the care they give to children (many older Aboriginal people have care-giving responsibilities for children). (Seniors' Education Centre, University of Regina, 1994)

v. *Programs are also needed to help support long-distance caregiving.*

The London InterCommunity Health Centre handbook also points out that long-distance caregiving is an increasing reality in today's dispersed families. (London InterCommunity Health Centre, 1997, Handbook "Caregivers: A Handbook for Family Caregivers")

vi. *Employers should be educated about the needs of informal caregivers to encourage increased workplace flexibility around caregiving.*

A survey done by the Caregivers Association of British Columbia found that over half of the caregivers are employed in the paid labour force and 31% said they

had to miss work for caregiving activities. More than one quarter (28%) of those interviewed felt that their work performance was affected by caregiving. (Caregivers Association of British Columbia, 1995, Survey Final Report, pp.13-21)

vii. *While support groups can be helpful, they must be only one link in a chain of practical support and respite services.*

A report written for the VON, Pembroke Branch, summarized studies on caregiver support groups. This synthesis found that support groups can actually have negative effects on caregivers unless they go beyond an opportunity for venting to link participants with needed information, with material and financial support, and with respite services within and outside the home. The researcher also cites a study by Kaye and Applegate which concluded that there is a need to balance sharing of the problems associated with caregiving with expressions of optimism, hope, pride and humour (Patti Hamilton for VON Pembroke, "Understanding Stress and the Family Caregiver", 1996, pp. 13-15).

Tools:

1. National Film Board videos on caregiving support with the working title "Caregivers" are to be completed in the summer of 1997. Call 1-800-267-7710 for information on how to obtain these videos.

2. A companion handbook for these National Film Board videos has been produced by the London InterCommunity Health Centre. Contact the National Film Board at 1-800-267-7710 to inquire about how to obtain the video(s)/handbook package.

3. The Caregivers Association of British Columbia has produced a Community Development kit which includes promotional and educational materials to help communities work together to encourage support for caregivers. The kit contains materials such as posters, buttons, clip art and examples of press releases as well as ideas of how to plan activities, fact sheets and examples of ways in which communities have worked together to put their creative ideas into action. For more information contact them at #170-216 Hastings Ave., Penticton, B.C., V2A 2V6, tel: (250) 490-4812, fax: (250) 490-4890.

4. The Pembroke VON-Home Support Program has produced a series of resources to help communities develop volunteer based, multifaceted support programs for older family caregivers. The resources include participant's and facilitator's manuals for training volunteers who will participate in the program. Contact Pembroke VON at 217 Pembroke Street East, 2nd floor, Pembroke, Ontario, K8A 3J8, tel: (613) 732-9993, fax: (613) 732-2415.

5. The Rural Senior Caregiver Support Project has produced a *Volunteer Manual for Community Support Persons.* For more information, contact Caregiver Alliance, 80 Bradford St., Unit 541, Barrie, Ontario, L4N 6S7, tel: (705) 734-9690, fax: (705) 734-0239.

C. **How Can We Intervene to Increase Personal Autonomy and Independence?**

TABLE OF CONTENTS

How Can We Encourage Seniors to Get Involved Generally?

Learnings:

i. *Varied informal means of communication which are part of seniors' everyday lives are the most effective means of recruiting seniors or informing them about programs.*

The project Savoir et Entraide pour un Vieillissement Éclairé found that word of mouth and personal contact were the most effective methods to recruit participants. The project Les médicaments, oui! non! mais... found Church bulletins to be effective, and the project L'apport inestimable des aînés in St.-Jérôme, Quebec used the Church's network to reach seniors. Seniors who are members of minority groups are particularly hard to reach in ways other than informal communication, partly because they are less likely to be part of seniors organizations. The Seniors for Personal Development project in Newfoundland made contact by telephone, word of mouth, posters, radio, church bulletins and volunteers. The Frontenac-Kingston Council on Aging Community Information Needs Assessment Project concurred with the other studies that seniors prefer to use informal communication methods. However, this project warns that often the presence of family and friends can be a factor which actually reduces information about formal services. (A Study of Seniors and Their Access to Information, 1996, p.23)

ii. *Keep the program flexible.*

Facilitators in the project Savoir et Entraide pour un Vieillissement Éclairé emphasized that facilitators should not try to control the process, but should let the participants take control. The Cooperative Action for Seniors project forged new partnerships by remaining flexible enough to respond to problems caused by a prolonged power blackout. Promoting flexibility should also extend to the roles of people involved in the program. For example, in the Cooperative Action for Seniors project, each peer advocate developed his or her own role differently. "One Peer Advocate assists seniors using the Seniors' Grocery Bus and another has developed a

friendly visiting role. All use the opportunities presented by their activities to pass on relevant information to other seniors." (St. John's Seniors Resource Centre, 1995, p.6)

iii. Take the time to develop true, equal partnerships.

The Elder Abuse Prevention Project used a partnership model of education which involved bringing together seniors and professionals to form integrated teams. While this method was successful in many ways, it was difficult to foster true partnerships between seniors and professionals and professionals often took the leading role. The project participants noted that it takes time and nurturing to develop true partnerships, and also recommended that more leadership development for seniors take place as an empowering force, to facilitate greater involvement and to prepare seniors for more active roles in partnerships. (Seniors' Education Centre, 1993)

iv. *To attract seniors from different cultural groups, integrate programs into traditional practices or activities.*

An elders group in the Northwest Territories supported the desire of elders to pass along their knowledge and traditions to younger persons in their community by developing a women's sewing group, traditional and cultural events, storytelling and information sharing workshops and a bible study gathering. (Enekniget Kalgiat - Elders Centre, 1993-94). This approach is also useful for seniors from the more mainstream cultures. Quilting bees have been used in some communities in a similar way. For example, a community in British Columbia designed and produced a community care quilt. As the pieces began to arrive, a traditional "quilting bee" emerged and participants from all ages came to learn the skill from seniors who had learned it many years earlier. Once finished, the care quilt was displayed permanently in the Town Hall. Some projects have warned that programs not interfere or compete with traditional or regular events.

v. *Encourage programs which promote intergenerational connections.*

The Seniors as Educators on Elder Abuse project found that part of the success of their Senior's Fair was that it promoted intergenerational communication because younger adults attended as representatives of agencies or just to pick up information of use in their personal or professional lives. A project in St.-Jérôme, Quebec offered

training sessions to seniors on the importance of developing relationships with other generations and to become leaders of intergenerational projects in their community. As an example of one such intergenerational initiative, a group of seniors and youth came together to discuss the problem of youth violence in the neighbourhood. After a few meetings, a number of youths decided to patrol the parks in small groups to ensure seniors' safety at night. Following this initiative, several local projects were revised to save some money which was then used to finance a youth centre. (Centraide Laurentides, 1991)

vi. *Use participants' manuals more than flip charts, videos and case studies in workshops and conferences involving seniors.*

The Age Wise project found that flip charts and case studies varied in their usefulness for senior audiences. (Fort Saskatchewan Seniors Advisory Board and the Alberta Association on Gerontology, 1995)

vii. *In programs which use senior volunteers, ensure that there are volunteer back-ups for every task to adapt to natural interruptions in volunteering which are characteristic of seniors' lives.*

Seniors may have more interruptions of volunteering because of changes in their living situations, health problems and other caregiving demands. The Centre for Seniors Windsor found that it is especially important not to rely solely on one volunteer for special skills and knowledge. This is not fair either to the volunteer or to the other seniors who attend the program. (Centre for Seniors Windsor, 1996)

viii. *Increase accessibility of any event or program planned.*

Several projects emphasized the importance of increasing accessibility by providing transportation, making sure the meeting place is physically accessible, reminding members of up-coming meetings, providing sensory supports such as hearing enhancement and special lighting and providing training and back-up for group leaders. (Canadian Council for Social Development, no date) The Roadside Senior Citizens Club took their education sessions out to various sites throughout the area and ultimately reached several hundred seniors in fifteen rural communities. Some projects suggest providing free bus transportation or other free transportation.

ix. *Use telephone contact rather than always relying on group meetings to maintain regular contact.*

Again, several projects found that total reliance on group meetings to maintain regular contact resulted in seniors losing interest in the program because of frequent absenteeism or difficulties getting to meetings. The Canadian Council for Social Development project found this particularly important for self-help groups.

x. *Hold events at times most convenient for seniors and remember to provide lunch and/or snacks.*

The Seniors as Educators on Elder Abuse project found that weekdays and especially Thursdays are the best days for functions. They also found that 10:00 a.m. to 2:00 or 3:00 p.m. with a lunch provided is best. (New Brunswick Gerontology Association, Fredericton Chapter, 1994)

xi. *Provide ongoing reinforcement of the value of seniors' participation*

The Cooperative Action for Seniors project found that "hearing about the benefits any of their actions have provided to seniors in need helps them to recognize that they can make a difference." (St. John's Seniors Resource Centre, 1995, Final Report, p.12-13)

xii. *Ensure that seniors continue to have influence over the program.*

In the St. John's Cooperative Action for Seniors Project, emphasis was placed on ensuring that seniors being helped determined their own goals and made their own decisions about action to be taken once they had been given information about the options available. (Final Report, p.11) The Haldimand-Norfolk Elder Abuse Task Force believed strongly in the importance of having project materials reviewed by the local literacy council for clear writing and also by seniors. However, attempts to form an older adult focus group for periodic review of materials proved more difficult than expected. (Haldimand-Norfolk Elder Abuse Task Force, 1996)

xiii. *Make sure that events are enjoyable.*

Many programs, even educational programs wove support or education into leisure or recreation activities. For example, Seniors for Personal Development used Performers for Literacy to help stress how literacy applied to seniors. They invited seniors and their grandchildren to an event at which Performers for Literacy were present and the seniors and children acted out familiar fairy tales with new twists.

xiv. *Promote advocacy among seniors.*

A number of projects pointed out that advocacy programs for seniors promote leadership, involvement and the realization of programs and policies which meet the needs of seniors.

Tools:

1. Action Through Advocacy, prepared by the Canadian Pensioners Concerned Incorporated/La Corporation Canadienne Des Retraités Intéressés, 1997, is a guidebook on advocacy for seniors organizations. For information on obtaining copies contact: Canadian Pensioners Concerned Inc., Suite 302, 7071 Bayers Rd., Halifax, N.S., B3L 2C2, tel: (902) 455-7684, fax: (902) 455-1825.

What Types of Skills or Education Programs will Best Contribute to Seniors' Independence?

TABLE OF CONTENTS

Learnings:

i. *Teaching seniors new skills or finding out more about their needs works best if it is part of a recreational and/or cultural activity such as a seniors fair or a seniors theatre production.*

This learning was repeated in many projects. For example, the project coordinators of Les aînés et l'interculturel found that it was very difficult to interest seniors in intercultural events for many reasons such as the novelty and difficulty of the subject, the challenge involved in reviewing one's own values and a general resistance to change. However, seniors were not adverse to talking about social issues and getting involved with people from different cultures as long as they were part of a

leisure activity such as an intercultural supper. Theatre is a very successful method of education with seniors, as the Jonquière, Québec project demonstrated.

ii. *Seniors appreciate learning from other seniors using approaches where they can share experiences.*

The Age Wise educational project in Alberta, which used volunteer senior facilitators to present workshops on aging issues, found that "strong senior involvement added great depth to the information extended and added significantly to the positive reception in most areas." (Fort Saskatchewan Seniors Advisory Board and the Alberta Association on Gerontology, 1995, p.12) Similarly, the Seniors as Educators on Elder Abuse project found that messages from seniors about seniors sound more authentic because their words come from their experiences.

iii. *However, seniors do not generally want to facilitate or co-facilitate formal workshops.*

The project Les Médicaments: oui! non! mais... found that their plans to use trained volunteer seniors to co-facilitate workshops on alternatives to medication for common problems was not successful. They found that most seniors approached felt this was too much of a burden and too difficult a task for them. The Age Wise project also had difficulty recruiting senior facilitators, but found that if they were encouraged and supported and made to feel comfortable, they performed well in the role.

iv. *Offer one-time practical learning sessions geared to specific needs of seniors.*

It may be daunting for seniors to sign up for a lengthy program of skills training. However, a literacy project in Renfrew County, called Generating Older Adult Learning, found that seniors may be more willing to participate in one-time sessions. This finding was supported by another seniors literacy program sponsored by the United Way of Calgary and Area, which offers workshops on such topics as: Keeping You Healthy (talking with doctors and learning about drugs); Helping you Bank (how to use a bank card, write cheques etc.); Reading and Writing to Grandchildren; and Understanding Business Letters. Similarly, the Network of Senior Ethnic Women in Metro-Toronto found that one-day workshops focussed on practical issues were more relevant to minority women than more ambitious conferences.

v. *Gear computer skills programs to increasing seniors' independence*

Members of a seniors centre in Medicine Hat, Alberta, believe that computer literacy is an essential part of independence for seniors. They formed a computer club and, using a New Horizons Program grant, purchased computer equipment and offered computer training courses to other seniors. The program was extremely popular: 144 seniors took a beginners course and 16 took an advanced course. Many others were on the waiting list. A similar project in Windsor Ontario focused a seniors computer course on such independence-enhancers as on-line computer home banking, shopping services, public library use and communication with others using e-mail. (Venier Centre Computer Club, 1994 and Centre for Seniors Windsor, 1996)

Tools:

1. The Veiner Centre Computer Club has various project materials which can help others create computer training courses for seniors. Contact the Veiner Centre, 225 Woodman Ave S.E., Medicine Hat, Alberta, T1A 3H2, tel: (403) 529-8383, fax: (403) 529-1050.

2. The Age Wise project, a joint endeavour of the Fort Saskatchewan Seniors Advisory Board and the Alberta Association on Gerontology created participants' and facilitators' manuals that were used in educational workshops in rural Alberta communities. Titles for the manuals are: *Finance; Housing and Transportation; Intergenerational Communication; Legal Issues; and Lifestyles.* To order the manuals for $25.00 or for more information, contact Brenda Higham, Fort Saskatchewan Seniors Advisory Board, Information and Resource Centre, Pioneer House, 10102-100 Avenue, Fort Saskatchewan, Alberta, T8L 1Y6, tel: (403) 998-7337/998-0150, fax: (403) 992-0192.

TABLE OF CONTENTS

Personal Health Practices:

Learnings:

i. *Physicians, other health care workers, as well as seniors and community members more generally need sensitization to identify and respond to early signs of problem drinking among seniors.*

A survey of health professionals undertaken by the Addiction Research Foundation revealed that early signs of problem drinking are not being identified. (Addiction Research Foundation, Alternatives Research Committee, 1996)

ii. *Better education on the risks of psychoactive prescription drugs should be targeted at older people generally, and older women in particular, their caregivers and health professionals.*

Older people generally, and older women in particular are the most frequent users of psychoactive prescription drugs. Yet aging also makes people vulnerable to problems of adverse drug effects and interactions. Further, physicians continue to prescribe inappropriately due to a lack of knowledge. (Addiction Research Foundation, Alternatives Research Committee, 1996)

iii. *More community kitchens, food co-ops, community gardens and community cooking groups are needed to reduce the risks of malnutrition and other health problems associated with the growth in poor seniors living alone.*

The Money Management for Health and Wellness for Native Seniors Project identified Native seniors as being at high-risk of poor nutrition, due in part to a lack of money. (Native Seniors Centre, 1996)

Tools:

1. *Promoting Choices: A Community Action Guide for the Safe Use of Alcohol and Medications by Older Adults* is a tool for mobilizing communities to promote safer use of alcohol and psychoactive medications by seniors. The guide is available from the Marketing Department, Addiction Research Foundation and is available in French as well as English. Contact: Addiction Research Foundation, Marketing Department, 33 Russell Street, Toronto, Ontario, M5S 2S1, tel: 1-800-661-1111.

2. Elliot Lake Retirement Living produced *Seniors' at Risk Manual: A Practical Guide to Care Providers, 1996.* This manual deals with substance abuse, self-neglect, mental health problems and elder abuse. Contact them at the Algo Centre Mall, 151 Ontario Avenue, Elliot Lake, Ontario, P5A 2T2, tel: (705) 848-4911.

Systemic Barriers (e.g. Housing and Transportation Needs)

TABLE OF CONTENTS

Learnings:

i. *Existing housing facilities can be adapted to promote seniors' involvement at relatively low cost for considerable benefits.*

For example, a tenants association in Alberta worked cooperatively with the property management company to create a greater sense of community and connectedness in a large seniors housing complex by outfitting the existing auditorium in the building for tenants' events.

ii. *Social housing should be designed or adapted to maximize opportunities for social support*

Social housing for seniors can include opportunities to eat together, to improve nutrition knowledge, to create opportunities to help each other manage chores or take medication, and to plan and arrange outings. (Greater Edmonton Foundation, 1996, pp.13-17)

iii. *Transportation is a major barrier to service access for many seniors.*

As mentioned earlier, many projects have emphasized the need to provide free transportation or to bring services to seniors because transportation poses such a major problem, particularly for rural and isolated seniors.

D. **How Can We Address Unresolved Policy and Service Concerns Surrounding End of Life?**

TABLE OF CONTENTS

Palliative Care:

TABLE OF CONTENTS

Learnings:

i. *Effective palliative care requires multidisciplinary teams and the use of volunteers as part of the care unit.*

Hospital staff in care units, surveyed through the project Accompagnement des mourants et de leurs proches, recommended that: to improve care for the dying in hospitals, a multidisciplinary approach is needed with increased participation of doctors and volunteers in these teams; and there must be increased communication between the various units and sectors of the hospital and more training on how to support a dying person for all hospital staff.

ii. *Trained volunteers can provide essential support and personal care for the dying person and for his or her family.*

The project Accompagnement des mourants et de leurs proches found that trained volunteers help overcome the loneliness of people who are dying in hospital. Their presence can increase the opportunities for the dying person to communicate his or her needs. They can facilitate the expression of feelings between the dying person and family members or friends, and can sometimes help caregivers plan specific care options adapted to the needs of the patient.

iii. *The active support of the hospital director, appropriate volunteer recruitment and excellent volunteer training as well as preparation of hospital staff for the introduction of volunteers are all essential to the success of a Palliative Care unit in a hospital.*

The above points were all findings of the project Accompagnement des mourants et de leurs proches.

TABLE OF CONTENTS

Legal/Ethical Issues:

Learnings:

i. *Adult protection legislation is not sufficient to prevent elder abuse.*

The Seniors Educating Seniors about Elder Abuse project found that to prevent elder abuse there is a need to involve seniors, seniors organizations and the general public to find strategies and solutions to address problems associated with elder abuse. They believe that educating and empowering seniors to be their own leaders will provide the most success.

Concerns:

i. *Increased reliance on family members for care may reduce reporting around elder abuse.*

The Seniors Educating Seniors about Elder Abuse project is worried that seniors will not want to report family members. Therefore, elder abuse will become even more hidden. They believe that transition houses for seniors are needed.

Tools:

1. A Code of Conduct was produce by Défi-Autonomie in Mont-Laurier, Québec, for the staff who work with seniors. The code deals with issues such as confidentiality and provides guidelines for alerting the organization and relevant agencies when health or other problems are identified. Contact: Défi-Autonomie d'Antoine Labelle, 610 de la Madone St., Mont-Laurier, Québec, J9L 1S9, tel: (819) 623-6681, fax: (819) 623-3081.

TABLE OF CONTENTS

V. CONCLUSION:

The ninety-six projects analysed for this report have produced a wealth of learnings and resources which point toward many practical directions for addressing the needs of a growing and increasingly diverse senior population, in an aging society with reduced resources.

To put these many learnings in perspective, this report will conclude by addressing briefly the five questions posed in the Introduction. While the answers to these questions cannot be seen as comprehensive or conclusive, they do provide the basis for dialogue to help seniors, their families, policy makers and front-line workers move closer to practical strategies for healthy-aging communities.

1. What are the most critical issues affecting the participation, health, well-being and risks of seniors?

There are many critical issues affecting the health, well-being, risk and participation of seniors in Canada. The aging of the population and the resulting increase in chronic health problems combined with the forced retirement of many younger seniors, the declining incomes of many seniors resulting from early retirement and reduced social benefits, and the fact that family caregivers are carrying a larger burden of informal care both for seniors and dependent adult children, create considerable challenges in meeting the needs of the current and emerging senior population as well as their informal caregivers. However, at the same time, the aging of the population provides increased visibility of the needs of seniors and escalates the influence that seniors as a group can exert on public policy and programs. Seniors today are also more active, more widely involved since a greater proportion of the senior population has been in the paid work force than ever before, more educated, and the seniors population as a whole is generally more healthy than ever before. The increased diversity of the seniors population, reflecting the increased diversity of Canada generally, also provides new opportunities for innovative thinking and creative solutions evolving from the contributions seniors make to society.

2. Which health determinants are most influential in improving health and ensuring that seniors live full lives?

Referring back to the main list of health determinants summarized in the Introduction, the findings of the 96 projects analysed reveal that social support networks, education and income stand out as the most important health determinants. The reduction of social isolation is undoubtedly the most influential in improving health since it has direct physical, psychological and social ramifications. However, there are other factors which are so closely tied to increased social involvement that they must be addressed if social isolation is to be reduced. The importance of higher incomes, better housing, better transportation, literacy training, cross-cultural as well as intergenerational interaction, and improved education about program resources, the effects of prescription medication and different realities of aging all were repeated many times throughout the projects.

3. When and how can we intervene around these health determinants to maximize the benefits of intervention?

Interdisciplinary wellness programs which address psychological, social, physical health and practical needs (such as house repairs), through preventive as well as acute care approaches, are needed. In addition, while most seniors favour intergenerational programs to increase social involvement and reduce age-based stigmatization, there is a need for some age-specific programs to address health determinants. Among the programs recommended were: seniors literacy training programs; support and counselling programs for senior survivors of elder abuse, spousal abuse or child abuse; and computer training programs for seniors. Training and sensitization of government officials, service providers, and the society at large about the realities of seniors is needed. To ensure that all programs and approaches build on the contributions, strengths as well as interests of seniors and respond to their needs.

4. What approaches provide good value for shrinking dollars?

While an interdisciplinary wellness program sounds ambitious and costly, there were many examples of very low cost programs which provided this range of approaches. For example, the therapeutic gardening program and the therapeutic dance movement program described in this report are excellent examples of low cost programmes which improve physical as well as psychological health and at the same

time build social networks. Another cost-effective approach to wellness is to hire an activity coordinator for a seniors housing complex or seniors centre. Programs are described in the report, which have produced multiple benefits in terms of reducing social isolation, improving physical and psychological health for hundreds of seniors and identifying issues so that they could be prevented before they became major problems, all for the cost of one coordinator's salary. Transportation programs also represent good value for the dollar because they give seniors access to existing programs and thus reduce the need for new programs. The many programs highlighted in this report which use volunteer outreach workers and advocates are also highly cost-effective. However, projects have cautioned that programs which use volunteers cannot be seen as free. Some salary dollars for a volunteer coordinator as well as support dollars to help volunteers with transportation or meal costs and to pay for volunteer recognition events will still be needed. In general, the projects analysed emphasized the benefits of community-based approaches which respond to the realities, strengths, contributions and needs of seniors and other community members.

5. Based on what we've learned, what are the next steps which should be taken at the policy and at the community levels to respond effectively to the contributions, needs and realities of people in later life?

This document is intended as a springboard to dialogue and resource sharing. Healthy-aging communities depend on citizen involvement, neighbourhood support building and community-relevant solutions to enhance the quality of life and recognize the contributions of seniors.

If this report can become a catalyst to these processes, then it has accomplished its purpose. Through information sharing, dialogue and action planning, we may come one step closer to a shared vision of a healthy-aging society.

TABLE OF CONTENTS

Bibliography

Access Concept Team, Caritas Group. (1995). *Access Project II, Steering Committee Application.* Edmonton, Alberta.

Addiction Research Foundation, Alternatives Project Committee. (1996). *Report on the Alternatives Project - Building for the Future.* Perth, Ontario.

Addiction Research Foundation. (1995). *Promoting Choices: A Community Action Guide for the Safe Use of Alcohol and Medications by Older Adults*. Toronto, Ontario.

Age-Wise Immigrant Seniors Project. (1994-1995). *Age-Wise Workshops: Legal Issues Facilitator's Manual; Legal Issues Participants' Manual; Intergenerational Communication Facilitator's Manual, Intergenerational Communication Participants' Manual, Lifestyles Facilitator's Manual, Lifestyles Participant's Manual.* Calgary, Alberta.

Aide aux Seniors Sudbury District East Home Support Program. (1996). *Hand in Hand, Manual for the Development of Adult Day Centres.* Prepared by Lorraine Mercer, Chantal Roy, Lorraine Leblanc and Brian Aitken. Noelville, Ontario.

Alberta Centre for Well-being. (1995). *The Well-being of Seniors in Alberta: Proceedings of the March 31, 1995 Meeting*. Edmonton, Alberta.

Alternatives Committee of Windsor-Essex County. (1996). *Older Adults Substance Misuse Project Description* and *Quarterly Report*. Windsor, Ontario.

Alzheimer P.E.I. (1994). *Memory Loss Needs Assessment*. Charlottetown, P.E.I.

Anctil, Pierre. (1990). *André Laurendeau, un intellectuel d'ici*, Presses de l'Université du Québec, Sillery, Quebec. Cited in Association internationale francophone des aînés, Montreal Chapter. (1995). *Rendez-vous d'automne, Cahier de sensibilisation*. Montreal, Quebec.

Aphasia Centre - North York. (1996). *Pictographic Communication Resources:Enhancing Communicative Access. (*Prepared by Aura Kagan, Joanne Winckel, Elyse Shumway and Carmela Catapano Simone) and funding approval form. North York, Ontario.

Aphasia Centre of Ottawa-Carleton. (1994-95). *Welcome Back! Community Reintegration for People with Aphasia Project Proposal* and activity reports. Ottawa, Ontario.

Arthritis Society. (No date). *Arthritis Self-Help Management Program Project Report* and *Leader's Manual*. Toronto, Ontario.

Association internationale francophone des aînés, Montreal Chapter. (1996). *Final Report*. Montreal, Québec.

Association internationale francophone des aînés/Quebec Association for the Defence of the Rights of the Retired and Pre-Retired, Montreal Chapter. (1995). *Rendez-vous d'automne, Les aînés et l'interculturel.* Montreal, Quebec.

Association québécoise pour la défense des droits des retraités-es et pré-retraités-es/Quebec Association for the Defence of the Rights of the Retired and Pre-Retired. (1995). *Final report: Projet Médic-Action*. Memphrémagog, Quebec.

Association québécoise pour la défense des droits des retraités-es et pré-retraités-es/Quebec Association for the Defence of the Rights of the Retired and Pre-Retired. (1994). *Final report: Projet Info 3e âge*. Montreal, Quebec.

Aware Press. (1992). *Guide des aînés (médicaments et alcool).* Cited in Elixir, *Final Report, Savoir et Entraide pour un viellissement éclairé project.* Sherbrooke, Quebec.

Barbeau, G. (1991) "Médicaments et Troisème Age", *Québec Pharmacie,* vol. 38, pp. 661-665. Cited in Association québécoise pour la défense des droits des retraités-es et pré-retraités-es. (1995). *Final report: Projet Médic-Action*. Magog, Quebec.

Biegel, D.E., Sales, E., and Shulz, R. (1991). *Family Caregiving in Chronic Illness*. Sage Publications. Newbury Park CA. Cited in Caregivers Association of British Columbia. (1995). *Caregivers to Adults in BC Telephone Survey, Final Report*. Penticton, B.C.

Bron, Paul. (1992). *Vieillir dans l'immigration,* editorial, 4ème Trimestre 92, Grenoble, France. Cited in Association internationale de francophones aînés, Montreal Chapter. (1995). *Rendez-vous d'automne, Cahier de sensibilisation,* Montreal, Quebec.

Calgary Seniors' Literacy Society, United Way of Calgary and Area. (1995). Calgary Seniors' Literacy Project various project materials. Calgary, Alberta.

Canadian Association on Gerontology. (1996). *Seniors at Risk: A Conceptual Framework.* Ottawa, Ontario.

Canadian Council on Social Development. (No date). *Seniors and Self-Help* (Self-Help Canada Series). Ottawa, Ontario.

Canadian Seniors Packaging Advisory Council (CASPAC), Packaging Association of Canada. (1995). *Packaging for an Aging Canadian Market: Projects Silver Market and Open Sesame, Final Report.* Willowdale, Ontario.

Canadian Pensioners Concerned Incorporated. (1994). *Final Report Programme for Action Project, and Action through Advocacy: A Guidebook on Advocacy for Seniors Organizations.* Halifax, Nova Scotia.

Canadian Mental Health Association. (1993). *Seniors Promotion and Awareness Campaign cover sheet.* Sudbury, Ontario.

Canadian Mental Health Association Nanaimo Branch. (1992). *An Analysis of the Survey Results of the Issues and Directions,* Seniors Health and Wellness Project. Nanaimo, B.C.

Capital Care-group. (1995-1996). *Innovations in Continuing Care newsletters, New Models in Continuing care Demonstration Project Draft Evaluation Plan* and related project materials. Edmonton, Alberta.

Caregiver Alliance of Simcoe County. (1996). *Rural Senior Caregiver Support Project : Quarterly Narrative Report Form and Volunteers Manual.* Barrie, Ontario.

Caregivers Association of British Columbia. (1995). *Caregivers to Adults in BC Telephone Survey, Final Report*. Penticton, B.C.

Caregivers Association of British Columbia. (1994). *Community Care Week*. (Promotional Material). Penticton, B.C.

Centraide Laurentides. (1991). *La pauvreté dans les Basses-Laurentides*. St-Jérôme, Quebec. Cited in Centre de recherche du Diocèse de St-Jérôme, 1996, *Bilan et perspectives*. St-Jérôme, Quebec.

Centre for Seniors Windsor. (1996). Computer Friends At-Risk Project various project materials. Windsor, Ontario.

Centre de recherche du Diocèse de St-Jérôme. (1996). *Bilan et perspectives*. St-Jérôme, Québec.

Chappell, N.L. (1992). *Social Support and Aging*. Butterworths. Toronto, Ontario. Cited in Caregivers Association of British Columbia. (1995). *Caregivers to Adults in BC Telephone Survey, Final Report*. Penticton, B.C.

Citizen Advocacy Society of Lethbridge, prepared by Donella Scott. (1995). *Evaluation: Seniors Independence Project, Citizen Advocacy Society of Lethbridge*. Lethbridge, Alberta.

Citizen Advocacy Society of Lethbridge. (1994). *Lethbridge Seniors Needs Analysis* (prepared by Sheri Bjorgum) and other project materials. Lethbridge, Alberta.

Comité des usagers du Centre hospitalier régional de l'Outaouais. (1995). *Évaluation, Accompagnement des mourants et de leurs proches.* Prepared by André Charette. Hull, Quebec.

Comité régional du 3e âge. (1994). *Évaluation du projet sur les médicaments chez les personnes de 55 ans et plus*. Prepared by Christine Olivier. Hull, Quebec.

Community Links Nucleus Group. (1994). *Progress Report 1992-1994.* Halifax, Nova Scotia.

Community and University Consultation Project. (1992). *Application Form.* Halifax, Nova Scotia.

Community Living London, McGrenere Resource Centre. (1993). *Seniors Independence Program, Program Impact Assessment.* London, Ontario.

Congress of Union Retirees - Canadian Labour Congress. (1993-94). Reaching Out Project various project materials. Ottawa, Ontario.

Cosmopolitan Industries Limited. (1995). SIP Grant: *Seniors Integration Project Completion Report*. Saskatoon, Saskatchewan.

Council on Aging for Renfrew County. (1994). *GOAL Program Co-ordinator's Final Report, September 30, 1994* and other project materials. Pembroke, Ontario.

Council on Positive Aging. (1993). *Project sheet.* Thunder Bay, Ontario.

Dance/Movement Therapy Association of Ontario (Ottawa office). (1994). *Movement for Health: Dance/Movement Therapy Programming with Seniors Project Summary.* Ottawa, Ontario.

Défi-Autonomie d'Antoine Labelle. (1995). *Final Report of the Recherche-Action devant mener* à *la mise sur pied de services de soutien* à *domicile de façon permanente sur le territoire de la Municipalité régionale du comté Antoine Labelle*. Mont-Laurier, Quebec.

Division of Aging and Seniors. (1996). *New Horizons Partners in Aging: Knowledge Development Framework.* (unpublished) Ottawa, Ontario.

Division of Aging and Seniors. (1996). *New Horizons Partners in Aging: Funded Projects, 1995-1996.* Ottawa, Ontario.

Division of Aging and Seniors. (1996). *Broader Determinants of Healthy Aging: A Discussion Paper.* (unpublished) Ottawa, Ontario.

Elder Abuse Resource Centre. (1992). *Volunteer Training Program: Trainer's Manual.* (prepared by Michael Case). Winnipeg, Manitoba.

Elixir. (1993). *Final Report, Savoir et Entraide pour un Viellissement Éclairé*. Sherbrooke, Quebec.

Elliot Lake Retirement Living. (1996). *Seniors' at Risk Manual: A Practical Guide to Care Providers.* Elliot Lake, Ontario.

Enekniget Katimayiit - Elders Group. (1993-94). Elders Group Project various project materials. Cambridge Bay, Northwest Territories.

Evergreen Hearing-Aiders. (1994). *Funding Approval Form.* Guelph, Ontario.

Federal, Provincial and Territorial Advisory Committee on Population Health. (1996). *Report on the Health of Canadians*. Toronto, Ontario.

Fédération de l'Âge d'Or du Québec. (1995). *Bilan Final, Complice en Action!, Projet intergenerationel de la FADOQ*. Montréal, Québec.

Fort Saskatchewan Seniors Advisory Board and the Alberta Association on Gerontology. (1994). Participants' and facilitators' manuals: *Finance, Housing and Transportation, Intergenerational Communication, Legal Issues* and *Lifestyles.* Fort Saskatchewan, Alberta.

Fort Saskatchewan Seniors Advisory Board and the Alberta Association on Gerontology. (1995). *Age Wise Workshops Final Report*. Fort Saskatchewan, Alberta.

Frontenac-Kingston Council on Aging, New Horizons Committee. (1996). *Community Information Needs Assessment Agency Study Volumes 1, 2 and 3.* Kingston, Ontario.

Gerontology Association of Nova Scotia. (1995). *Report on Needs Assessment for Senior Women as Victims of Violence, and Impact Questionnaires.* Kentville, Nova Scotia.

Greater Edmonton Foundation. (1996). *Proceedings: Supportive Housing for Seniors, Rising to the Challenge* (conference May 2-3 1996, Edmonton). Edmonton, Alberta.

Haldimand-Norfolk Elder Abuse Task Force, Adult Mental Health Services of Haldimand-Norfolk. (1996). Various task force materials. Hagersville, Ontario.

Halton Seniors Home Safety, Project Advisory Committee, Oakville-Trafalgar Memorial Hospital (Project Supervisor). (1996). *Halton Seniors' Home Safety Project Final Report*. Oakville, Ontario.

Headlines Theater Company. (1992). *This Is My Life?, Final Report, Parents and Aging Project*. Vancouver, B.C.

Health Canada. (1995). *Conceptual Framework New Horizons: Partners in Aging. (unpublished)* Ottawa, Ontario.

Health Canada. (1993). *Conceptual Framework Seniors Community Programs*. (Unpublished) Ottawa, Ontario.

Kane, R.L. (1990). Introduction. In R.L. Kane, J.G. Evans, & D. MacFadyen (Eds.). *Improving the Health of Older People: A World View*. Oxford University Press. New York. pp. 341-345.

Kingston Sexual Assault Crisis Centre. (1995). *Quality Therapeutic Intervention for Senior Women Survivors of Sexual Assault Funding Approval Form.* Kingston, Ontario.

Leclerc, Gilles, Richard Lefrançois, Normand Poulin. (1992). *Viellissement actualisé et santé, rapport de recherche*. Université de Sherbrooke. Cited in Elixir. (1993). *Final Report, Savoir et Entraide pour un Viellissement Éclairé*. Sherbrooke, Quebec.

Les aînés(e)s de Jonquière. (1996). *Bilan d'étape, Centre d'information et de référence sur les médicaments chez les aîné(es).* Prepared by Paul Girard. Jonquière, Quebec.

London InterCommunity Support Project. (1995). Various project materials. London, Ontario.

Meadowcroft Tenants Association. (1995). *Wellness in Meadowcroft*. Edmonton, Alberta.

Ministère de la Santé et des Services sociaux et l'Association canadienne de l'industrie du médicament. (1993). *L'utilisation des médicaments chez les personnes agées.* Cited in Association québécoise pour la défense des droits des retraités-es et pré-retraités-es. (1995). *Final report: Projet Médic-Action*. Magog, Quebec.

Ministère de la Santé et des Services Sociaux. (1992). *Politique de services* à *domicile pour personnes qui présentent des limitations d'activités et leur milieu respectif*, Quebec. Cited in Défi-Autonomie, *Action-Research Final Report*. Mont-Laurier, Quebec.

Morden Services for Seniors Meal Programs Committee. (1995). *Program Application and Form Interim Report.* Morden, Manitoba.

Native Seniors Centre. (1996). Money Management for Health and Wellness for Native Seniors Project various project materials. Edmonton, Alberta.

Network of Senior Ethnic Women. (1996). *Final Evaluation of Project Network of Senior Ethnic Women, Report of Conference.* Toronto, Ontario.

New Beginnings for Youth Inc. (1996). *Helping Hands...Community Tool Kit Funding Approval Form.* Nepean, Ontario.

New Brunswick Gerontology Association, Fredericton Chapter. (1994). *Seniors as Educators on Elder Abuse: Final Report, and program Application.* Fredericton, New Brunswick.

New Horizons Green Thumb Seniors. (1996). *The Green Thumb Program*. Prepared by Paul Allison. Victoria, British Columbia.

North West Territories Seniors Society. (1996). *Senior Public Service Announcements and Elder Abuse Workshops, 1995-1996) Final Project Report.* Yellowknife, North West Territories.

Older Women's Survival Project (OWLS) and Annette McCullough. (Forthcoming). *Guidebook for Facilitators of Support Groups for Older Women who are Survivors of Abuse*. Calgary, Alberta.

Older Women's Survival Project (OWLS) and Annette McCullough. (1995). *A Handbook for Older Women who have Survived Abuse* and various project materials. Calgary, Alberta.

One Voice: The Canadian Seniors Network. (1994). *Older Workers and Canada's Aging Labour Force: Research Report* and *Final Report and Recommendations*. Ottawa, Ontario.

Ottawa West Seniors Support Services. (1995). *Community Bridges Funding Approval Form and Highlights Report.* Ottawa, Ontario.

Pioneer Manor - Regional Municipality of Sudbury. (1996). *The Prescription Drug Utilization Project Executive Summary* and *Older Adults & Medications: Ask Questions. There may be alternatives...* (booklet). Sudbury, Ontario.

Prince Edward Island Association for Community Living (prepared by Christine Weatherbie). (1995). *Inform and Include - Seniors: A Prince Edward Island Study on Aging and Mental Disabilities*. Charlottetown, P.E.I.

Province of British Columbia. (1993). *New Directions for a Healthy British Columbia*. Crown Publication Inc. British Columbia. Cited in Caregivers Association of British Columbia. (1995). *Caregivers to Adults in BC Telephone Survey, Final Report*. Penticton, British Columbia.

RAISE Home Support service for the Elderly. (1996). *Funding Approval Form, RAISE Home Crisis Response.* Kitchener, Ontario.

Regional Continuing Care Services. (1996). *Project Proposal Outline and other project materials.*. Edmonton, Alberta.

Roadside Senior Citizens Club. (1995). *Application Form and Activity and Accounting Report.* Summerville, Bonavista Bay, Newfoundland.

Sandy Hill Community Health Centre. (1995). *Seniors Cooking Together Project Activity Report*. Ottawa, Ontario.

Saskatoon Council on Aging. (1995). *Isolation and Older Adults Project First Annual Report*. Saskatoon, Saskatchewan.

Schizophrenia Society of Saskatchewan. (1993). *Seeking Security - Now and in the Future: Guidelines for Estate Planning and Wills for Parents of Persons with Psychiatric Disabilities*. Regina, Saskatchewan.

Schizophrenia Society of Saskatchewan (prepared by Sandra Taylor-Owen). (1994). *Wills and Trusts Project: Evaluation of Project*. Regina, Saskatchewan.

Senior Advisory Council for the Region of Sudbury. (1994). *The Promotion of Seniors Well-Being Through the Development of the Councils on Aging Network of Ontario.* Sudbury, Ontario.

Senior Support Services. (1994). *An Interim Report, Seniors' Friendly Visitor Project.* Prepared by John B. Collins & Associates. Surrey, B.C.

Senior Support Services. (1995). *A Second -Year Interim Report, Seniors' Friendly Visitor Project*. Prepared by John B. Collins & Associates. Surrey, B.C.

Senior Support Services. (1995). *A First Year-End Report, Seniors' Friendly Visitor Project*. Prepared by John B. Collins & Associates. Surrey, B.C.

Senior Support Services. (1995). *Second Interim Report, Seniors' Friendly Visitor Project.* Prepared by John B. Collins & Associates. Surrey, B.C.

Seniors for Seniors Co-Op Inc. (1995). *Final Report (form) and application for Apello project.*Winnipeg, Manitoba.

Seniors Peer Support Advisory Board of Western Manitoba. (1995-1996). *Application Form and Proposal, Evaluation Report for Senior Peer support Training Program in Russell, Manitoba, Seniors Peer Support Training Programme Facilitator's Manual, Participants Manual.* Brandon, Manitoba.

Seniors Serving Seniors. (1996). *Evaluation Report, Senior Peer Counselling of Penticton Program*. Prepared by Pat May and Ann Reimer. Penticton, B.C.

Seniors' Education Centre, University of Regina. (1991). *Elder Abuse Prevention Project Phase I: Literature Review*. Regina, Saskatchewan.

Seniors' Organization Advancement Project, Alberta Council on Aging. (1995). Various project materials. Edmonton, Alberta.

Seniors' Education Centre, University of Regina. (1993). *Elder Abuse Prevention Project Phases Two, Three and Four* and *Elder Abuse Prevention Project Phase Five*. Regina, Saskatchewan.

Seniors' Education Centre, University of Regina, in cooperation with the Saskatchewan Indian Federated College and the Gabriel Dumont Insititute. (1994). *"Elder's Visions": The Saskatchewan Older Aboriginal Adults' Learning Needs Assessment Project - Phase One, Final Report*. Regina, Saskatchewan.

SHARE. (1996). Widow to Widow - New Beginnings Project various project materials. Kitchener, Ontario.

Southeast Regional College, Whitewood District Campus. (1995). *Seniors' Independence Project Report.* Whitewood, Saskatchewan.

Speakers Advocates and Group Educators for Seniors (S.A.G.E.S.) (1996). *Final Report, Project Overview, application form and other project material.* Winnipeg, Manitoba.

St. James Assiniboia Seniors Centre Inc. (1993-1996). *Application for Funds Grant Form; Background Information, Community Resources, Request for Extension, Newsletters.* Winnipeg, Manitoba.

St. John's Seniors Resource Centre. (1995). *Application Summary, Final Report for Co-Operative Action for Seniors; Evaluation of the Cooperative Action Program (prepared by Andy Rowe Consultants).* St. John's, Newfoundland.

Statistics Canada. (1991). Selected Statistics for Census Subdivisions, 1991 Census - 100% Data. Cited in Caregivers Association of British Columbia. (1995). *Caregivers to Adults in BC Telephone Survey, Final Report*. Penticton, B.C.

Stone, R., Caffereta, G.L., and Sangl, J. (1987). *Caregivers of the Frail Elderly: A National Profile*. Paper presented at the annual meeting of the Gerontological Society of America, San Francisco, California. Cited in Caregivers Association of British Columbia. (1995). *Caregivers to Adults in BC Telephone Survey, Final Report*. Penticton, B.C.

Tamblyn, R. (1994). "Questionable Prescribing for Elderly Patients in Quebec", *Canadian Medical Association Journal*, vol. 150, no 11, pp. 1801-1809, cited in Association québécoise

pour la défense des droits des retraités-es et pré-retraités-es. (1995). *Final report: Projet Médic-Action*. Magog, Quebec.

The Four Villages Community Health Centre. (1994). Seniors Determining Seniors' Health Project various project materials. Toronto, Ontario.

The Sandwich Generation Coalition (prepared by Lee Fleming and Janet Marshall). (1994). *Sandwich Generation Needs Assessment*. Charlottetown, P.E.I.

Veiner Centre Computer Club. (1994). Various project materials. Medicine Hat, Alberta.

Ventures in Independence Alberta/NWT. (1996). *Steady as You Go: A Guide for Seniors to Assess their Risks for Falling.* Edmonton, Alberta.

Victoria Order of Nurses Home Support Program. (1995-1996). *Start Right Here!! Guidelines for One-to-One Caregiver Support*; *Understanding Stress and the Family Caregiver: A Guide for Service Providers and their Families; Caregiver Helpline Notes; A Time for Me Participants' Handbook; A Time for Caregivers; Companion Manual.* Pembroke, Ontario.

Victorian Order of Nurses, Medicine Hat and District (now Alberta South). (1995). *Teeoda Lodge Adult Day Support Model Proposal*. Medicine Hat, Alberta.

Victorian Order of Nurses, Halton Branch. (No date). *Special Steps: A Walking/Visiting Program for Persons experiencing Alzheimer and/or Related Disorders* and other project materials. Oakville, Ontario.

Volunteer Resource Centre. (1993- 1995). *Seniors Peer Matching Service or The Joy of Friendship Final Report, The Friendly Visitor's Handbook, Program Impact Assessment, Proposal* and other project materials. Sydney, Nova Scotia.

Weaver, Lynda. (1994). *How to do Simple Program Evaluation on Seniors Health Promotion Programs(done as part of Dance/Movement Therapy Association of Ontario project).* Ottawa, Ontario.

West Prince Seniors Committee. (1993). *Activity Levels of Seniors in West Prince: A Needs Survey* and other project materials. Alberton, Prince Edward Island.

Windsor Community Living Support Services. (1996). Social/Personal Integration of Seniors with Disabilities Transition Program various project materials. Windsor, Ontario.

Women's Health Clinic. (1993-1995). *Funding Proposal, four Progress Reports, Coming of Age:Images of Healthy Aging for Women (video), Information Sheets, Community Resource*

Directory, Content Manual, Final Report and Recommendations (prepared by Madelyn Hall). Winnipeg, Manitoba.