RESEARCH REPORT
External Research Program

Adapting Municipal Housing to Meet the Needs of Older Tenants With Dementia

Canada

CMHC SCHL
HOME TO CANADIANS

Canada Mortgage and Housing Corporation (CMHC) has been Canada's national housing agency for more than 60 years.

Together with other housing stakeholders, we help ensure that Canada maintains one of the best housing systems in the world. We are committed to helping Canadians access a wide choice of quality, affordable homes, while making vibrant, healthy communities and cities a reality across the country.

For more information, visit our website at **www.cmhc.ca**

You can also reach us by phone at 1-800-668-2642
or by fax at 1-800-245-9274.

Outside Canada call 613-748-2003 or fax to 613-748-2016.

Canada Mortgage and Housing Corporation supports the Government of Canada policy on access to information for people with disabilities. If you wish to obtain this publication in alternative formats, call 1-800-668-2642.

ADAPTING MUNICIPAL HOUSING
TO MEET THE NEEDS OF
OLDER TENANTS WITH DEMENTIA

Prepared by

Myra Schiff, Ph.D.
Myra Schiff Consultants Limited

and

Nancy Gnaedinger, M.A.
Consultant in Gerontology

CMHC Project Manager
Luis Rodriguez

August 1997

This project was carried out with the assistance of a grant from Canada Mortgage and Housing Corporation under the terms of the External Research Program. The views expressed are those of the authors and do not represent the official views of the corporation.

NOTE: **DISPONIBLE AUSSI EN FRANÇAIS SOUS LE TITRE:**

Adapter le logement social aux besoins des locataires âgés atteints de démence

Purpose

This study was undertaken to find out about the growing number of people with dementia living in municipal housing. It is hoped that this study will increase the awareness of municipal housing providers about the nature of the problem and suggest ways in which they can address the issue. The successes attained by three of the four case studies included in the report (one of them has yet to be implemented) should encourage municipal housing providers to develop their own programs to respond to the needs of their current and future tenants with dementia.

Acknowledgements

This study could not have been completed without the cooperation of the 275 municipal housing providers who responded to our initial questionnaire. We appreciate the assistance of the individuals in the provinces and territories who supplied us with the names of municipal housing providers in their jurisdictions. We are also grateful to all those who agreed to be interviewed as part of the case studies that were carried out in Lethbridge, Alberta; Dufferin County, Ontario; Yarmouth, Nova Scotia; and Mont St-Hilaire, Québec. Thanks are also due to Luba Serge and Janet McClain for their work on the case studies in Mont St-Hilaire and Yarmouth.

Abstract

An aging population and fewer long-term care beds means growing numbers of Canadians with dementia will be living in the community, many of them in buildings managed by municipal housing providers.

This study investigates the extent to which municipal housing providers are aware of and concerned about tenants with dementia and their expectations about this situation in the future; the steps they are currently taking to address the situation and how they see themselves responding in the future; and the barriers they find to making changes to the physical environment or to management policies and procedures, and how to overcome these.

Responses to a mailed survey from 250 municipal housing providers revealed that

- Housing providers who are aware of and concerned about older tenants with dementia in their buildings are making efforts to support those tenants as well as other frail tenants.
- Providers who are not aware of tenants with dementia in their buildings appear to be doing little to prepare for such a situation in the future.
- Housing providers' efforts to accommodate older tenants with dementia include working with health and social services agencies and with families, providing education on dementia to staff and other tenants, increasing the monitoring of special tenants by their own housing staff, and making minor physical modifications to buildings.
- Barriers to making changes that would accommodate the needs of older tenants with dementia include cost (identified much more frequently than any other barrier), lack of staff in housing agencies, lack of skill in managing persons with dementia, and concerns about turning their seniors housing into long term care facilities.

Case studies were carried out in each Lethbridge, Alberta; Dufferin County, Ontario; Mont St-Hilaire, Québec; and Yarmouth, Nova Scotia. These revealed that it is possible to develop programs which help tenants with dementia remain in their apartments while ensuring the safety and security of other tenants. These programs, however, were typically developed to assist and support all frail residents; they were not designed solely to meet the needs of tenants with dementia.

Executive Summary

The physical and operational design of municipal housing for seniors was based on the assumption that if and when senior tenants needed supervision and care, they would move to special long term care facilities. A shortage of long term care beds means that this assumption no longer holds true. Municipal housing providers are now challenged by numerous factors related to increasing numbers of tenants with dementia.

The Canadian Study on Health and Aging estimates that there are approximately 250,000 Canadians 65 and over who have some form of dementia, and that about half of these people live in the community. The number of Canadians with dementia is expected to increase to 450,000 by the year 2011. This increase, coupled with current trends whereby older adults increasingly remain in the community, means that both the number and percentage of people with dementia living in the community will increase significantly.

In 1995-96, Dr. Myra Schiff and Nancy Gnaedinger conducted a national study which investigated

- the extent to which municipal housing providers are aware of and concerned about tenants with dementia and their expectations about this situation in the future;

- the steps they are currently taking to address the situation and how they see themselves responding in the future; and

- barriers to making changes to the physical environment or to management policies and procedures, and how to overcome these barriers.

Research methods included a literature search, a mailed questionnaire to municipal housing providers in every province and territory, and four case studies.

The literature search uncovered no published material on this topic.

The 250 completed responses to the survey revealed that

- Housing providers who are both aware of and concerned about the presence of tenants with dementia in their buildings are clearly making efforts to support those tenants and other frail tenants. The providers who are not aware of tenants with dementia in their buildings appear to be doing little to prepare for such a situation in the future.

- Housing providers' efforts to accommodate tenants with dementia include working cooperatively and collaboratively with health and social services agencies and with families, providing education on dementia to both staff and other tenants, increasing the monitoring of special tenants by their own housing staff, and making minor physical modifications to buildings (modifications which typically support all frail older residents).

- The most frequently mentioned barrier to making changes to accommodate increasing numbers of tenants with dementia was cost. Three kinds of costs were identified: the cost of providing more supervision, the cost of modifying buildings and the cost of

moving tenants from a facility to one that is more suitable. Other frequently mentioned barriers include lack of staff in housing, lack of skill in managing persons with dementia, resistance to and fear of turning seniors housing into long term care facilities, and the inappropriate design of buildings that were built when there was no expectation that frail, cognitively impaired people might be living there. Working cooperatively with other agencies (e.g., home support services such as Home Care and CLSCs in Québec, mental health service organizations, provincial ministries and regional departments of health, the Victorian Order of Nurses, long-term care facilities, psychiatric facilities) is the main strategy for overcoming these barriers.

Case studies were carried out in each Lethbridge, Alberta; Dufferin County, Ontario; Mont St-Hilaire, Québec; and Yarmouth, Nova Scotia.

In each case, it was found that

- Housing providers are making concerted efforts to maximize the quality of life of their tenants with dementia, while ensuring the safety and security of their other tenants. A common response is to provide some form of assisted living for those residents who require it; some services are provided and staff are on site on a 24 hour basis. In some cases physical renovations have been proposed to further support the concept of assisted living. Other responses included enlisting the help of other tenants and increasing other tenants' awareness and understanding of the needs of tenants with dementia.

- The housing organizations in these four communities have developed programs which help tenants with dementia to remain in their apartments.

- These programs, however, were typically developed to assist and support all frail residents; they were not designed solely for tenants with dementia.

The four case studies describe four quite different approaches used by municipal housing providers to respond to the needs of tenants with dementia. Despite the differing approaches, some common themes do emerge.

- None of these initiatives was developed specifically to deal with tenants with dementia. This suggests that programs designed to promote aging in place can be adapted to respond to the needs of tenants with dementia. It is hoped that this finding will encourage other housing providers to review existing programs to identify how they can promote aging in place for tenants with dementia. Furthermore, providing a similar program for all tenants, regardless of cognitive status, clearly offers a financial advantage.

- All the programs responded to individual circumstances. No one approach will be appropriate for all housing providers. Effective program planning requires housing providers to be aware of the context within which they are working. In order to be successful, the program must fit with the needs, preferences, abilities and life-styles of the tenants who are being served.

- The Housing Authorities took advantage of opportunities as they presented themselves. With the possible exception of the OMH in Mont St-Hilaire, the schemes were developed

in response to opportunities which presented themselves.

- Successful programming requires persistence and flexibility. Although persistence and flexibility are important for the successful development of any type of program, these case studies offer ample evidence of their importance. For example, both the Lethbridge Housing Authority and the Dufferin County Housing Authority have made multiple efforts to achieve their goals. In Mont St-Hilaire, the OMH and the CLSC have also made changes to the program as necessary.

The results of the study results suggest that the following actions could assist housing providers in responding to the needs of older tenants with dementia.

- Increase awareness among housing providers and managers about the potential implications of dementia. Although just over half the survey respondents reported having one or more tenants with dementia, few appeared to have developed a systemic response to the problem. Housing providers need to be made aware of the projected prevalence of dementia and of the increasing probability that their buildings will be home to a growing number of people with these disorders.

- Encourage housing providers to develop a plan to respond to this situation. Once housing providers are aware of the problem, they need to plan a response. Responding to individual cases will prolong the time the resident can remain in the housing, but a more comprehensive approach will help the provider develop a response which considers the needs of all stakeholders, including non-demented tenants, families, housing staff and administration. A more comprehensive approach will also allow housing providers to consider how to provide for the safety of all tenants within the constraints imposed by the existing structure, financial constraints, and the organization's mandate. Such a plan could also provide guidance about when a person with dementia would need to move to a higher level of care.

- Help housing providers get the information, education and training they require about dementia and dementia care. When asked what they need to know to deal with tenants with dementia, respondents said that their most important need was to know about dementia -- its signs, its stages, its consequences, how to manage tenants with dementia, and at what stage these special tenants must be placed in a long-term care facility. They also need to know who can help them, and they need to know how to make their buildings safe and secure for all tenants.

- Ensure that staff of the agencies they work with have the information and skills to provide good dementia care. Since the most common response to having tenants with dementia was to work with other agencies, it is important to ensure that agency staff are able to provide quality dementia care.

Developing a response to the growing presence of tenants with dementia will require balancing a number of complex factors.

- An Issue of Equity. A strategy for accommodating residents with dementia will have to address the question of whose needs are to be met and which perspectives will be incorporated into the response. The strategy must respond in an equitable and balanced

manner to the needs of residents with dementia and the non-impaired, since both groups have the right to a safe and secure environment which helps them function independently and maintain a good quality of life.

The response should consider all residents' right to age in place. The importance of meeting the needs of residents with dementia must be tempered by the recognition that municipal housing should not "become a nursing home". It is important to ensure that municipal housing continues to attract new residents, who have both the right and the need to take advantage of this kind of living.

- Legislative and Regulatory Barriers. A number of respondents referred to the legislative and regulatory barriers to responding to the presence of tenants with dementia. The most frequently mentioned was the mandate of the housing provider, and the question of whether its role was to provide shelter ("bricks and mortar") or whether it also includes the provision of services, an issue which often involves other levels and sectors of government. Another factor which must be dealt with is an individual's right to refuse assistance.

- Funding Sources. Responding to the presence of tenants with dementia involves additional costs, and costs were the most frequently mentioned barrier to making changes. This raises the question of who will pay for additional services, a particularly thorny issue in a time of increasing financial restraint.

  Each housing provider will have to arrive at its own resolution of where the increased funding will come from. To the extent that this is viewed as a provincial, as opposed to local, issue, discussions should take place between the ministry responsible for health and the ministry responsible for housing in each province.

The projected increase in the number of older adults with dementia, combined with the decreased number of long-term care beds, means that municipal housing will be home to a growing number of tenants with dementia, whether housing providers plan for them or not. Planning to meet their needs will improve the quality of life for tenants who are cognitively intact as well as those with dementia. It will also ease the job of Housing Authority staff and Board, as well as community service providers who are an important component of community living for the elderly.

In summary, this report describes a two stage study. The first stage consisted of a national survey of municipal housing providers; the second consisted of four case studies of municipal housing providers who had developed programs which help older tenants with dementia to age in place. Following presentation of the study results, the report contains discussion of some of the major themes and important issues that emerged.

Table of Contents

Introduction 1

Background Research 2

Overview of Research Method 3

Survey Sample 3

Results 4

Case Studies 18

Discussion 50

Final Notes 52

End Notes 53

List of Tables

Table 1 -- How Respondents Learned Tenants Had Dementia 5

Table 2 -- Adoption of Strategies (All Respondents) 6

Table 3 -- Adoption of Strategies (Respondents Having Tenants with Dementia) 7

Table 4 -- Adoption of Strategies 8

Table 5 -- Ratings of Strategy Effectiveness for Promoting Safety of Tenants with Dementia 10

Table 6 -- Ratings of Strategy Effectiveness For Promoting Safety of Other Tenants . . 11

Table 7 -- Rating of Importance of Objectives in Deciding What Actions to Take 13

Introduction

The Canadian Study on Health and Aging estimates that there are approximately 250,000 Canadians 65 years of age or older who have some form of dementia; about 161,000 of these have Alzheimer Disease. It is estimated that half of the 250,000 Canadians with dementia live in the community.

The number of Canadians with dementia is expected to increase to 450,000 by the year 2011. This increase, coupled with current trends whereby older adults increasingly remain in the community, means that both the number and percentage of people with dementia living in the community will increase significantly.

Many seniors with dementia will live in municipal housing which was not designed to accommodate their special needs. In fact, some of these buildings already contain residents with dementia who were cognitively intact when they moved in, but have since become impaired.

Although municipal seniors' housing was not intended, either in terms of design or policy, for seniors with dementia, changing demographics combined with government policies encouraging "aging in place" mean that this housing is indeed becoming home to an increasingly frail and impaired population.

This is a situation of potential concern, since residents with dementia may pose a safety risk to themselves or other tenants. Many of these residents cannot look after their own needs, and require assistance with activities of daily living, including personal hygiene, preparing and eating meals, and taking medications. As the disease progresses, they may need regular supervision to ensure they do not engage in activities which jeopardize their well-being or that of other tenants.

The likelihood that multi-unit seniors' buildings will contain an increasing number of residents with dementia leads to a need to understand how housing providers can respond to this situation. The research reported in this document addresses this need.

For many years, the majority of research on accommodation for people with dementia focused on those who were living in long-term care settings.[1,2,3] More recently, the range of research on design for dementia has expanded to address the accommodation needs of people with Alzheimer Disease who are living in their own homes, whether it be an apartment or a single family dwelling.[4,5,6]

The published work in this field addresses design issues related to purpose-built health care facilities and private residences only. It does not address issues of the physical environment or policy related to seniors' multi-unit accommodation provided by municipal and non-profit organizations. Therefore, a major objective of this study was to identify possible actions that can be taken to meet the needs of people with dementia living in multi-unit accommodation.

More specifically, the research was designed to develop an insight into the following issues related to accommodating people with dementia in municipal housing units:

1. To what extent are current housing providers aware of and concerned about the problem? What are their expectations about this in the future?

2. What steps, if any, are current housing providers taking to address this situation? How successful do they believe they are? How do they see themselves responding to the problem in the future?

3. What are the barriers to successfully introducing or implementing changes which are meant to address this issue? Are there any "tricks" or "secrets" to successfully dealing with the problem at the present time or planning for the future?

It is likely that housing developed by charitable non-profit organizations also contains seniors who have developed dementia since moving into the building. Nevertheless, the research focused on municipal housing providers for the following reasons:

- CMHC has an established reputation with municipalities as a source of information and ideas for seniors' housing options;

- the budgets and mandates for some municipal housing providers may be more constrained than those of charitable non-profit organizations;

- available time and budget for this research was limited and a priority had to be established.

The study focused on existing housing, rather than looking at any new initiatives which have been purpose-built for seniors with cognitive impairments, because most residents of municipal seniors' housing live in "standard" buildings and this is where the potential problem is most acute.

Background Research

In order to allow the researchers to develop a well-informed questionnaire, work on this project began with a literature search and networking with knowledgeable individuals to identify any previous work that had been done on this topic.

A search of on-line data bases (using intersections of key words such as Alzheimer Disease, dementia, apartments, and housing) failed to yield any published material addressing the research topic.

Similarly, networking with individuals in the field of municipal housing and in dementia care did not result in any suggestions about written material relating to the issue of how municipal housing providers are responding to the presence of people with dementia.

Overview of Research Method

Data were collected in two stages. In the first stage, questionnaires were mailed to 375 municipal housing providers across Canada. These were used to identify housing providers' perception of the problem, what they are currently doing to accommodate tenants with dementia, and what they perceive as the barriers to dealing with the problem. The questionnaires were also used to identify municipalities which have carried out initiatives that allow people with dementia to remain in their housing units; these were then contacted to participate in detailed case studies.

The questionnaire was structured to make it easy for respondents to complete. Close-ended questions were used wherever possible, and open-ended questions were used where appropriate. A reminding letter card was sent to all potential respondents approximately two weeks after the initial mailing. French versions of the research material (cover letters, questionnaires and reminder cards) were sent to all sample respondents in Quebec. (A copy of the English and French versions of each of these documents is included in Appendix A.)

Survey data were entered into SPSS for analysis. Responses to open-ended questions were input verbatim into a word processing program; responses from Québec were translated and then entered into the data base.

The second stage of the research consisted of conducting four case studies. The objective was to identify successful initiatives by municipal housing providers in responding to the needs of tenants with dementia in their housing. Special emphasis was placed on those who are making changes to policy, rather than responding on a case by case basis. An initial review of survey data identified 17 providers who could be considered for these case studies. After an initial telephone screening, the list was reduced to four organizations. These agreed to participate in detailed case studies which were designed to explore a number of questions related to the success of their initiatives.

Survey Sample

Developing the sample for this study proved to be a challenge. There does not exist a national list of municipal housing providers, nor a list of municipal and charitable non-profit housing providers combined.

The sample was developed by contacting a key individual responsible for housing in each of the provincial and territorial governments. Each jurisdiction was invited to participate in the study and requested to provide a list of municipal housing providers in their jurisdiction.

Six of the twelve individuals contacted suggested sending the survey to them; of these, one contacted the authors after receiving the questionnaire to suggest they contact municipal housing providers directly, and this was done. In two of the jurisdictions there were very few such providers; all these providers were included in the sample. One of the remaining four jurisdictions had recently reorganized its local housing providers so that municipal and charitable housing organizations in an area were combined into a single housing authority. The authors obtained a list of all housing authorities in the jurisdiction which included municipal housing, and this became part of the sample also.

The remainder of the sample consisted of 90 municipal housing providers from each of the remaining three jurisdictions. In two of these jurisdictions, the ninety names were chosen at random. In the third jurisdiction, the government was interested in exploring the issue of people with dementia in municipal housing, and so set some conditions for their participation. One condition was that a separate analysis of their data be undertaken; the second was that they select the sample. As a result, the sample from this jurisdiction consisted of 22 selected municipal housing providers; the remaining 78 were chosen at random.

The final sample consisted of 375 organizations, representing all provinces and territories. Replies were received from 250 respondents from eight of the twelve provinces and territories. The high completion rate of 66.7% is felt to reflect in part the interest that municipal housing providers have in the study topic. Although not random, the sample did provide instructive information about how municipal housing providers across Canada are responding to people with dementia living in their buildings.

Results

Respondents reported being responsible for an estimated total of 111,400 housing units in approximately 13,500 buildings. The estimated total number of tenants was 140,800, of whom an estimated 46,000 are seniors.

Just over half the respondents (128 respondents, 51.2%) reported being aware of senior tenants in their buildings "who have, appear to have, or are said to have dementia (such as Alzheimer Disease)".[7] 111 of the 128 respondents replied to a question about the estimated number of people with dementia in their buildings. The estimated numbers ranged from 1 to 130; the modal estimate was 4.43.

Respondents were asked to indicate the sources from which they had learned the tenants had a form of dementia. Their responses are shown in the table below.

Table 1

How Respondents Learned
Tenants Had Dementia

Information Source	Number Mentioning
Tenants Association	20
Social Club	10
Another Tenant or Tenants	75
Visiting Homemaker, Nurse or Other Paid Home Care Provider	64
Tenant's Family	55
Housing Staff	37
Physician	11
Other	12

As shown in Table 1, the most commonly cited source was other tenants, followed by paid Home Care providers and tenants' families.

Because the safety of tenants with dementia, and the safety of other residents in the building, is always of concern to housing providers, respondents were asked whether tenants with dementia had ever done anything to make the respondent feel concerned about the fact that these seniors were living in their buildings. A total of 161 specific concerns were cited. (Coding allowed for each respondent to mention a total of 3 concerns. If a respondent cited more than three different concerns, the coder used her judgement about which ones to include.)

Safety -- of the person with dementia and of other tenants -- was clearly the issue of greatest concern to respondents. The most common specific concern, mentioned by 41 respondents, was about the potential for a fire -- leaving the stove, oven or kettle on, or actually causing cooking fires. Five respondents cited general issues relating to safety and security. An additional 16 respondents referred to other specific safety issues -- falling, fainting, fires, smoking, guns, admitting strangers to the building, or simply that tenants with dementia could not be left alone.

Twenty seven respondents referred to various aspects of tenants' disorientation -- wandering, getting lost, going outside, and leaving the building. An additional seven references were to getting lost inside the building, going into other residents' apartments, locking themselves out, or losing keys or belongings.

Fourteen respondents mentioned ways that the affected tenant disturbs his or her neighbours -- making noise, knocking on their door, etc.

Housing providers were then asked what they had done to respond to their concerns about tenants who had demonstrated behaviour that made them concerned. Their most frequent

response was to contact the tenant's family. Alternatively, they contacted a social agency (such as Home Care or a CLSC if in Québec), a doctor, hospital or mental health professional, a community relations worker or on-site housing staff person to monitor the situation. In some cases housing providers were very active; for example, they would meet with the family, take fuses out of a stove, or set up a buddy system right away. The least common response was to make arrangements to move the tenant to a long-term care setting.

In order to develop a more comprehensive understanding of how providers were responding, we listed six possible strategies and asked them to indicate the status of each strategy (have implemented, planning to implement, have considered, not considered). Table 2 shows the results for all respondents.

Table 2

Adoption of Strategies
(All Respondents)

Strategy Description	Have Implemented This	Planning to Implement	Have Considered	Not Considered	No Answer
develop a new policy	14 (5.6)	12 (4.8)	51 (20.4)	116 (46.4)	57 (27.8)
change an existing policy	12 (4.8)	8 (3.2)	45 (18.0)	124 (49.6)	61 (24.4)
make physical changes to buildings	27 (10.8)	7 (2.8)	28 (11.2)	137 (54.8)	51 (20.4)
provide education and training for staff and administration	59 (23.6)	10 (4.0)	52 (20.8)	86 (34.4)	43 (17.2)
increase our staff	3 (1.2)	2 (0.8)	15 (6.0)	170 (68.0)	60 (24.0)
work with other agencies	125 (50.0)	4 (1.6)	45 (18.0)	49 (19.6)	27 (10.8)

The most commonly used strategy was to work with other agencies; fully half the respondents had implemented this measure. Almost one quarter (23.6%) of the respondents had provided training and education for staff. The least common strategy was to increase staff.

Answers to this question from only those respondents who reported having tenants who "have, appear to have, or are said to have dementia (such as Alzheimer Disease) are different from the answers from all respondents, when analyzed separately (see next table).

The groups who have tenants with dementia report working more with others agencies (24% more than "all respondents") and are more likely to have provided education and training for staff (16.2% more than "all respondents"). The strategy of increasing staff continues to be the least likely to have been implemented.

Table 3

Adoption of Strategies
(Respondents Having Tenants with Dementia)
(N = 128)

Strategy Description	Have Implemented This	Planning to Implement	Have Considered	Not Considered	No Answer
develop a new policy	9 (7.0)	7 (5.5)	33 (25.8)	50 (39.1)	29 (22.7)
change an existing policy	10 (7.8)	3 (2.3)	29 (22.7)	55 (43.0)	31 (24.2)
make physical changes to buildings	20 (15.6)	6 (4.7)	17 (13.3)	65 (50.8)	20 (15.6)
provide education and training for staff and administration	51 (39.8)	6 (4.7)	29 (22.7)	26 (20.3)	16 (12.5)
increase our staff	3 (2.3)	0 (0.0)	14 (10.9)	82 (64.1)	29 (22.7)
work with other agencies	95 (74.2)	2 (1.6)	20 (15.6)	8 (6.3)	3 (2.3)

The responses of those who did not have tenants with dementia are shown below. In general, the pattern here is similar to those shown in the previous two tables. It is understandable that none had increased their staff, but only 6.8% had provided education and training for staff --

and fully 50% had not considered it. The most striking pattern, however, is that there is little evidence that these respondents are thinking ahead about a problem which may arise in the future.

Table 4

Adoption of Strategies
(Respondents With No Tenants with Dementia)
(N = 117)

Strategy Description	Have Implemented This	Planning to Implement	Have Considered	Not Considered	No Answer
develop a new policy	5 (4.3)	5 (4.3)	18 (15.4)	66 (56.4)	23 (19.7)
change an existing policy	2 (1.7)	5 (4.3)	16 (13.7)	69 (59.0)	25 (21.4)
make physical changes to buildings	7 (6.0)	1 (.9)	11 (9.4)	72 (61.5)	26 (22.2)
provide education and training for staff and administration	8 (6.8)	4 (3.4)	23 (19.7)	60 (51.3)	22 (18.8)
increase our staff	0 (0.0)	2 (1.7)	1 (0.9)	88 (75.2)	26 (22.2)
work with other agencies	30 (25.6)	2 (1.7)	25 (21.4)	41 (35.0)	19 (16.2)

Respondents were asked to elaborate on their activities, to allow us to develop a better understanding of the specific implementation of these strategies. Since the most common strategy was to work with other agencies, one should not be surprised that the most common form of open-ended response related to working collaboratively with other agencies, such as health and social services, mental heath services, police and others. Examples of this type of response include:

> Our agency has had to down-size. Depend more on partnerships for support from the professionals in the field.

> The Local Housing Authority has recently submitted a joint proposal with Community Care to access funding to provide supportive housing in the form of one and a half co-ordinators and four full time home care workers to work

exclusively in our buildings. This service will also consist of a 24 hour health emergency number. The program is not exclusively for dementia, but should assist with some of the concerns.

Good cooperative relationship exists with staff of housing authority and other community agencies. Manager is member of Regional Mental Health Educational Group.

The next most common strategy reported was arranging for education about dementia to be delivered to both staff and tenants. The following are some examples of this type of response:

Peer counselling and training for leadership development within housing community.

All staff have had training related to tenants with dementia where applicable.

Utilize Alzheimer education courses to sensitize staff.

Other strategies include increasing the amount of time staff spend on supervision and monitoring.

We recently have appointed one of our staff to a community relations position. One of this person's responsibilities will be to work closely with the tenants and other agencies, such as Coordinated Home Care and VON. We will be trying to facilitate the seniors staying in their apartments as long as possible, through having supports from the above two agencies.

Changes in management policies which allow tenants with dementia to remain in their apartments were also reported.

Expanded "housing mandate" to accommodate those with mild dementia. We employ a full time activities coordinator. The purpose of the program is to provide a social atmosphere that enhances or maintains function as well as providing entertainment.

Recently pursued New Horizons Grant to establish an "aging in place" floor within existing building. This would include 24 hour supervision/care. Also are moving from resident "caretakers" -- i.e., maintenance staff on site, to resident "monitors" -- paying more attention to physical changes in tenants.

Allow seniors to transfer to all senior locales from mixed buildings if they desire. When working with frail elderly or those with various forms of dementia, this can at least place someone away from risks presented by non-senior social problems tenants and often allows a better environment that may have an in-place "buddy system", senior to senior.

Some respondents also described making physical changes to buildings that will increase tenants' safety and security.

Some tenant committees have access to fixed dwellings. Installation of memory aids and security signs. Some adaptations can be brought about in collaboration with the CLSC.

We submitted a proposal to develop a community centre by building in the space and connecting some of the units for day care and respite. The government of the day was interested but never gave official approval.

In-house safety and security measures -- life call and green card system with floor captains. Safety audits.

Returning to more structured questions, the authors were interested to know how effective respondents found these strategies, and asked them to rate them on two different dimensions -- first with respect to promoting the safety of tenants with dementia in their building(s).

Table 5

Ratings of Strategy Effectiveness
For Promoting Safety of Tenants with Dementia

Strategy Description	Very Effective	Effective	Not Sure	Not Too Effective	Not At All Effective	Not Applicable, No Answer
Developed a new policy	4 (1.6)	15 (6.0)	23 (9.2)	3 (1.2)	4 (1.6)	201 (80.4)
Changed an existing policy	7 (2.8)	9 (3.6)	26 (10.4)	5 (2.0)	2 (0.8)	201 (80.4)
Physical changes to building(s)	7 (2.8)	17 (6.8)	18 (7.2)	4 (1.6)	5 (2.0)	199 (79.6)
Education and training for staff and administration	21 (8.4)	45 (18.0)	20 (8.0)	4 (1.6)	2 (0.8)	158 (63.2)
Increased staff	3 (1.2)	7 (2.8)	10 (4.0)	2 (0.8)	8 (3.2)	220 (88.0)
Work with other agencies	57 (22.8)	61 (24.4)	22 (8.8)	9 (3.6)	4 (1.6)	97 (38.8)

When evaluating the safety of tenants with dementia, respondents felt the most effective strategy involved working with other agencies. Education and training for staff and administration were

considered the next most effective strategy, with just over a quarter of the respondents considering it either very effective or effective.

While the safety of tenants with dementia is clearly an important criterion, housing providers are also very concerned about the safety of the non-demented tenants in their buildings. In the next question, respondents were asked to rank the same six strategies with respect to how effective they had been in promoting the safety of other tenants in those buildings which also contain tenants with dementia.

The results of that ranking are shown in Table 6.

Table 6

Ratings of Strategy Effectiveness
For Promoting Safety of Other Tenants

Strategy Description	Very Effective	Effective	Not Sure	Not Too Effective	Not At All Effective	Not Applicable, No Answer
Developed a new policy	8 (3.2)	11 (4.4)	21 (8.4)	3 (1.2)	1 (.4)	206 (82.4)
Changed an existing policy	8 (3.2)	8 (3.2)	25 (10.0)	5 (2.0)	1 (0.4)	203 (81.2)
Physical changes to building(s)	5 (2.0)	16 (6.4)	21 (8.4)	4 (1.6)	4 (1.6)	200 (80.0)
Education and training for staff and administration	16 (6.4)	43 (17.2)	21 (8.4)	2 (0.8)	3 (1.2)	165 (66.0)
Increased staff	6 (2.4)	3 (1.2)	8 (3.2)	3 (1.2)	7 (2.8)	223 (89.2)
Work with other agencies	47 (18.8)	54 (21.6)	27 (10.8)	6 (2.4)	2 (0.8)	114 (45.6)

Rankings about activities which would promote the safety of other tenants are similar to those for promoting the safety of tenants with dementia, though the strength of the ratings is somewhat diminished. While 47.2% rated working with other agencies as effective or very effective in promoting the safety of tenants with dementia, this reduces to 40.4% rating it is effective or very effective for promoting the safety of other tenants. Similarly, 26.4% thought education and training for staff was effective or very effective for promoting safety of tenants with dementia, but this number was reduced slightly to 23.6% with respect to promoting the safety of other tenants.

Respondents were again asked respondents to indicate any other strategies or procedures they may have implemented to respond to tenants with dementia in their buildings. While most responses fell into the same categories obtained previously (working collaboratively with other agencies, arranging for education about dementia to be delivered to staff and tenants, increasing the amount of time staff spend on supervision and monitoring, and making physical and program changes to building that will increase tenants' safety and security) we also obtained some different kinds of responses, many of which convey a value of community development and self-reliance.

> Help between tenants may be one solution. The support of volunteer groups or groups with minimum funding can also help with mild cases.
>
> We are always on the lookout for devices -- like stove timers. We also alert the neighbourhood if we see a tenant wanders in a particular pattern -- although persistent wandering usually means they are at risk to themselves.
>
> We feel we must give priority to the education of other tenants and personnel. Find one person specifically responsible and accessible. Increase the security systems, e.g. smoke and heat detectors. Modify communal areas so as to facilitate identification, e.g. painting the building door a special colour, paint a line to the exit.
>
> Have other tenants keep an eye on them. Building manager checks twice daily

In order to develop an understanding of what housing providers consider important when making decisions about how to accommodate tenants with dementia, the researchers identified a number of objectives which housing providers might consider before deciding how to respond to the situation. Respondents were asked to rate these objectives with respect to "how important it has been, is, or is likely to be in helping you decide what actions to take." Responses are shown in Table 7.

Table 7

Rating of Importance of Objectives in Deciding What Actions to Take

	Very Important	Important	Not Sure	Not Too Important	Not At All Important	No Answer
Enhancing the safety of the tenant with dementia	128 (51.2)	52 (20.8)	15 (6.0)	1 (0.4)	4 (1.6)	50 (20.00)
Helping the person with dementia to live independently	65 (26.0)	80 (32.0)	41 (16.4)	7 (2.8)	4 (1.6)	53 (21.2)
Increasing the length of time the tenant with dementia can remain in your housing	50 (20.0)	68 (27.2)	64 (25.6)	5 (2.0)	8 (3.2)	55 (22.0)
Enhancing the safety of other tenants	146 (58.4)	38 (15.2)	8 (3.2)	5 (2.0)	4 (1.6)	49 (19.6)
Reducing stress for other tenants	114 (45.6)	61 (24.4)	14 (5.6)	4 (1.6)	4 (1.6)	53 (21.2)
Increasing staff's and administration's comfort with tenants with dementia	72 (28.6)	73 (29.2)	32 (12.8)	13 (5.2)	6 (2.4)	54 (21.6)
Increasing staff's and administration's ability to manage disruptive incidents successfully	107 (42.8)	60 (24.0)	19 (7.6)	4 (1.6)	7 (2.8)	53 (21.2

The most important objective was enhancing the safety of other tenants; almost 73% of respondents rated this as very important or important. Approximately the same percentage (72.0%) said that enhancing the safety of tenants with dementia was very important or important.

The third most important item was reducing stress for other tenants, rated as very important or important by 70% of the respondents. This compares with 58% rating of very important and important for helping the person with dementia to live independently. The goal rated least important was increasing the length of time the tenant with dementia can remain in their current housing; only 47.2 % rated that as very important or important, and an additional 25.6% said they were not sure.

These respondents clearly recognize the importance of addressing residents' safety in planning how to respond to dementia in their buildings. It is notable, however, that these respondents also place greater emphasis on the needs of other tenants (reducing stress for other tenants) than on the needs of the residents with dementia ("helping the person with dementia to live independently" and "increasing the length of time the tenant with dementia can remain in your housing".)

The final questions were open-ended. The first one asked "In general, what kinds of changes to social housing for seniors do you think would be most effective in helping you accommodate tenants with dementia in the future?"

Many respondents mentioned that more staffing would allow needed supervision and monitoring of residents, liaison with social and health services providers, and on-site activities. Recognizing that "people with dementia need a caretaker first and foremost", respondents called for "highly trained ... full-time ...in-house staff" who do not have to be "with the local housing authority".

Another change that could help in the future was modest physical changes to buildings, such as security systems, security locks on all outside doors, resident-specific door alarms, colour coding on elevators, doors and exits; and modest changes to interior design and appliances, such as locked cabinets for medication and "stove minders" for ranges.

(It should be noted that many of the examples of physical modifications described by survey respondents are not reported here because they were examples of modifications meant to promote "aging in place" generally, not for people with dementia specifically. This reveals the need, among housing providers, for more education about dementia.)

Other changes that could help providers accommodate tenants with dementia were said to be, in decreasing order of importance: the development of a type of enriched or supportive housing, including specialized suites, communal space, "on-site 24-hour response", "added services", and a cafeteria-style dining area; the provision of education for both staff and tenants; networking among housing, health and social service organizations; clustering tenants in one building or one floor of a building to make security and service delivery more efficient; and the provision of day programs.

Clearly these suggestions are not mutually exclusive. Many of the features suggested -- such as on-site, 24 hour supervision and surveillance, clustering of tenants for both security and efficiency of service delivery, the provision of day programs -- combine to make a picture of supportive housing. In fact, when these suggestions are combined into one concept they far outweigh the call for more staff.

The survey asked about perceived barriers to making such changes. Cost was the most frequently mentioned barrier. Three kinds of costs were identified: the cost of providing more

supervision ("the biggest barrier will be money ... needed for 24 hour per day monitoring"); the cost of modifying buildings ("current facilities require extensive renovations to accommodate these tenants") and the cost of moving tenants from a facility to one that is more suitable ("It's very costly to bring people together in rural areas").

Other barriers include, in order of importance, lack of staff, lack of education and training for staff, resistance to and fear (among tenants, their families and housing staff) of turning seniors' housing into long term care facilities, the inappropriate design of buildings, a lack of skilled workers in rural areas, and human rights and legislative concerns (for example, tenants' right to refuse assistance.)

Respondents were also asked what suggestions or advice they would give to other social housing providers who have older tenants with dementia.

Their first advice is to network and work pro-actively with health and social service providers and with families.

> Ensure that other health care agencies such as Home Care, family and friends are involved and responsible to provide services and that once the person cannot live safely... they are placed in alternative accommodation.
>
> Form a local coordinating committee in your area to include all caregivers, housing, clergy, etc. and work as a team -- it's much easier and more efficient.

Other advice is to provide supervision and monitoring for tenants with dementia; provide education about dementia to administration, front line staff and tenants; work with and be concerned about other tenants; create buddy systems in the buildings; transfer the tenant(s) with dementia to an appropriate long term care setting; and finally, adapt your buildings.

The next question asked respondents to list the organizations they would find it helpful to consult or collaborate with in order to better respond to the needs of tenants with dementia. It is encouraging to note the great variety of responses obtained, and even the number of different organizations that were cited by individual respondents. This range and number of responses strongly suggests that housing providers have been able to identify resource groups with whom they can collaborate when the need arises.

The most common responses dealt with the wide variety of community agencies -- home support services such as Home Care (and in Québec the CLSCs), Alzheimer societies, The Canadian Mental Health Association and local mental health service organizations, provincial ministries and regional departments of health, physicians and other health care professionals; police, senior centres, the VON (Victorian Order of Nurses), long-term care facilities, psychiatric facilities, Adult Protection Services, Red Cross, friendly visiting programs, tenants associations, churches, crisis centres and families.

When asked how these organizations could help, providers responded that by far the best way to help is by providing a regular and frequent on-site presence. Activity programs (in and out of the buildings), meal programs (in and out of the building), help with activities of daily living, house cleaning and friendly visiting programs are all needed.

> Regular visits by competent contact.
>
> Day care -- program during the day. Night care -- someone to stay at night.
>
> Feed, bath, dress, clean home, do laundry, shop, etc.
>
> Provide day to day life skills assistance and offer advice.
>
> Provide necessary support care to tenant to insure tenant safety, health and comfort within the apartment building.

Organizations can also help by providing follow up to crisis situations; education and training for housing staff, tenants and tenants' family members; a 24-hour on-call service; and on-site nursing services.

> Provide support and education.
>
> Would provide strong case management approach. Protect safety and security
>
> Provide 24 hour on-call services.
>
> Educate staff -- on-site and property managers. Modify units where possible.

Respondents also felt these other organizations could help with assessment of residents and referral to other organizations or settings when necessary.

> They help with assessments, so you know if they can stay on their own.
>
> Arrange alternate housing.
>
> Determine when the enhanced setting is no longer suitable and refer the resident to the next level.

The final question asked municipal housing providers to describe the most important things social housing providers need to know to address the problem of an increasing number of tenants with dementia living in their housing.

They state very strongly that, first and foremost, they need to know about dementia -- its signs, its stages, its consequences, the needs of people with this illness, how to manage tenants with dementia, and at what stage these special tenants must be placed in a long-term care facility for their own and for other tenants' safety. They also need to know who to go to (and where) for help -- they want names and telephone numbers. Finally, they need to know how to make their buildings safe and secure for their tenants with dementia and for the other tenants.

> Learn to understand the illness. Able to see the first stages and learn what stages follow. Who is the best source of information about this illness and who would most effectively help in an emergency.

> What agencies are available for support to caregivers and tenant. Gain knowledge of the disease from its onset. Provide support and refer for assessment. Develop a working relationship with physician and family.
>
> Experienced professional people must be involved in the supports. Site staff must be trained, educated to recognize signs of problems or potential concerns.

It should be noted here that some survey respondents stated clearly that their mandate does not include providing health care and supervision of tenants (although there was no question specifically asking about this).

> Tenants with late dementia should not be maintained in public housing due to putting other tenants at risk.
>
> We are not a nursing home. To provide the proper care for tenants with dementia would require medical and supervisory staff.
>
> We are a housing provider, not a social agency. We are not interested in making changes.

On the other hand, most responses indicated strong commitment to maintaining the highest possible quality of life for tenants with dementia, and a reluctance to move them to institutional settings, except as a last resort.

Case Studies

Although the survey results provide an over-all picture of how municipal housing providers are responding to the needs of tenants with dementia, case studies serve as a vehicle for a more detailed understanding of specific initiatives.

This section contains case studies of four housing providers who have developed programs which extend beyond the more common responses, such as contacting families and working with community agencies, and which are believed to increase the ability of tenants with dementia to remain in their housing longer.

A review of the questionnaires identified eighteen Housing Authorities which appeared to meet the criteria of having a program which promoted aging in place for tenants with dementia. A screening interview was held with a representative of each of these Authorities, and four were chosen to participate in a detailed case study. In selecting housing providers to participate in the case studies, an effort was made to select a mix of program types as well as to select programs from different areas of the country. The four which were chosen are not necessarily the four best programs, but they do provide a cross-section of efforts across Canada.

Case Study #1 -- Lethbridge Housing Authority

Lethbridge Housing Authority
1003 Lethbridge Centre Tower
400 - 4 Avenue South
Lethbridge AB
T1J 4E1

Contacts

Marion Marchant
Administrator
Tel. (403) 329-0556
Fax. (403) 327-3906

Chris Schonbrun
Coordinator
Tel. (403) 329-0556
Fax. (403) 327-3906

1. Context

The Lethbridge Housing Authority is a Public Non-profit Society, enabled under the Social Housing Act of Alberta to administer subsidized housing programs for seniors, families and people with special needs, in public and privately owned accommodation.

Tenants must be physically and mentally capable of looking after themselves in an independent apartment setting. Assistance from Home Care or health related services is allowed and encouraged in some cases. If a tenant's need becomes greater than what can be brought into the building, then it is likely the tenant will be asked to move to the next level of care. This is a flexible policy, however, depending on the level of a tenant's family support. Some seniors have considerable family support, and this can extend their time in an apartment. Each situation is dealt with on the basis of an individual tenant's needs and circumstance.

There are four buildings in the City of Lethbridge for seniors (three high-rises and one two-storey walk-up building) and one bungalow-style building in a small town:

Leonard C. Halmrast Manor - 142 suited (119 bachelors, 22 one-bedroom, and one two-bedroom), ten stories, located downtown.

W. D. L. Hardie Manor - 101 suites (45 bachelors, 50 one-bedroom, five large one-bedroom conversions, one two-bedroom), five stories, located in a suburban neighbourhood close to a shopping mall.

Russel T. Haig Tower - 136 suites (135 one-bedroom, one two-bedroom), sixteen stories, located downtown.

Courtland Place - nine one-bedroom apartments, two-storey walk-up, no common area, located downtown.

Garden Villa - a bungalow-style building with 10 one-bedroom units, in a rural location in the Town of Magrath.

These buildings are home to 500 senior tenants (aged 60 and over). Approximately 80% are female, 80% live alone, and approximately 10% are considered frail (meaning that the Administrator and staff keep a watchful eye on these tenants to ensure that changes in their behaviour are reported within 48 hours).

The Administrator visits each building three times a week and sees residents regularly. The Administrative Assistant sees residents on an as-needed basis. The Housing Authority does not have a Community Relations Worker; necessary visits to tenants are made by staff, day or night.

Resident caretakers in four of the buildings see tenants daily. In Hardie Manor, the caretaker lives off-site and a retired couple live rent free in exchange for monitoring the building after the caretaker's working hours. There has been a purposeful shift in recent years to hire caretakers who are skilled in working with people, and who are willing and able to monitor tenants' welfare and changes, first, and manage buildings second.

There are several other ways the Housing Authority takes responsibility for tenant welfare. A "Nite Out" meal service is delivered to each building one evening a week (by a catering service headed by a well-respected chef). The residents buy tickets in advance and are encouraged to invite family and friends. Arrangements are made for tenants who prefer to have a meal delivered to their apartment. Turn-out at these events has exceeded expectations and continually increases.

Another creative approach to improving tenant welfare is offering accommodation for out-of-town family members in hospitality suites - bachelor apartments in each of the seniors' buildings which are furnished with the essentials, including linens. Family members can visit, or give support during time of illness or relocation of a tenant to a higher level of care, while staying in the same building as their senior family member. The nightly charge is about one-sixth of a hotel. This accommodation is made possible by vacancies in bachelor apartments. Some tenant couples who need extra space because of illness or disability have been offered joined bachelor suites, inexpensively and temporarily converted to a double bachelor, with a common entrance.

The landlord encourages tenants to be active and to take initiatives (such as doing the gardening around their own building), and tries not to make too many rules.

The Housing Authority works with all available support services in the City: the Chinook Regional Health Authority, private Home Care providers, physicians, hospitals, social workers, CMHA (Canadian Mental Health Association) mental health programs, and police. The working relationship with these human service agencies is close. Problems are not simply referred by the Housing Authority; referrals are always followed up, and sometimes require advocacy work to ensure swift action by others. Inter-agency consultations are held to assess a tenant's capacity to continue living independently.

Another important connection to the human services is through the Housing Authority Board. The policy to appoint a Board member from the medical profession has enabled Administration to access medical help or health support for a tenant when other avenues do not work. Other

Board members are from a wide range of professions - all are said to be "people with heart". Board membership is for four years, so the Directors become very familiar with the situations of tenants.

In addition, Board members and staff of the Housing Authority are community-minded and participate on a number of public service committees, campaigns, and causes, volunteering their time to raise the Housing Authority's profile. It is understood that such activity and networking is key to good working relations with both public and private sectors. Staff are hired as much for their understanding and empathy as for their specific skills.

Housing Authority staff participate on formal municipal committees (Social Services, Health Care) to promote the development of policies and procedures which will ensure the timely implementation of action plans to benefit clients. Staff also lobby the three levels of government and attend workshops and conferences, all with the aim of improving the quality of life of their tenants.

Information sharing about individual tenants with service providers is done on a one-to-one basis, as is advocacy. Confidentiality matters are apparently not an issue, since problem-solving between the Housing Authority and social and health service providers is seen as a cooperative effort, involving trade-offs in information.

2. Tenants with Dementia

It is estimated that there are 50 to 75 tenants with dementia in the Authority's seniors' buildings, although staff note that it is difficult to determine the exact number, because of the different stages of the disease and different perceptions among observers. These tenants' symptoms and behaviours include paranoia, inability to do financial management (for example, losing pension cheques and not comprehending the concept of rent), deteriorating personal hygiene, inability to shop or prepare meals, and forgetfulness about taking medication. Their needs are primarily for surveillance, supervision and assistance with the activities of daily living.

Staff regularly hunt for misplaced pension cheques so that rent can be paid, groceries purchased, and so on. "One hour's effort on my part, hunting for a cheque, can give the tenant another month or more living in her own home."

There have been specific situations with tenants that have been very challenging. For example, an older male tenant who could no longer manage meal preparation and was therefore taking his dinner regularly with a kindly neighbour couple, became paranoid that the couple was trying to poison him, and tried to kill them with knife and gun. A neighbour called the caretaker, who called the police, an ambulance and the Administrator. The paranoid man was taken away. The Administrator immediately contacted the family members of the shaken neighbours and arranged for support services to ensure that counselling was available to them right away. The Administrator also followed up with the tenant who had been stabbed, after she was home from hospital.

In another situation, an elderly widow with no family members in the vicinity, deteriorated into paranoia and hallucinations. Neighbours notified staff, who found the tenant sitting on a stool with a machete fighting off invisible assailants. The Administrator contacted her family, but

when they did not respond, Mental Health was contacted and the woman was placed in a hospital, where she soon died, before her family arrived. The Housing Authority was left to clean out her apartment, which the family did not do.

A third story involves financial abuse. An elderly woman who did not speak English, and who appeared to live a very isolated life, was showing signs of dementia. She could not remember the identity of people in photographs around her apartment. She bought groceries and then threw them out. Well-meaning neighbours would bring her food. Her bank called the Housing Authority when they noticed her bank balance dropping suspiciously. This was at the same time that a community member was making overtures to move the tenant out. The Housing Authority staff did some careful observation and discovered that this community member was having cheques signed over to her by the confused tenant. They interceded, involved the police, and did not allow the tenant to move in with this person.

Each situation has been treated individually, depending on the behaviour and prognosis of the tenant and the availability of family support. As a rule, if management of a tenant's behaviour becomes too difficult, and if other tenants are put at risk, then alternative accommodation is sought.

3. The Response

It is a principle of the Housing Authority to take each individual's situation into account when responding to difficult situations. It is also their practice to respond creatively to tenants' needs; for example, providing the Nite Out dinners and hospitality suites. It is recognized, however, that the Housing Authority needs to be ready to respond to the changing needs of tenants in a proactive and long term way.

Several factors contributed to the long term response that the Lethbridge Housing Authority has developed: increased level of frailty (including dementia) and longevity of tenants and increased frequency of related crises; increased number and range of home support services for seniors and noticeable duplication of service being delivered to seniors' buildings; limited accommodation options for older frail persons in Alberta; tenants' dread of having to move to a nursing home; and a constant vacancy rate for bachelor apartments in the Housing Authority's seniors buildings, and resulting revenue losses.

The Lethbridge Housing Authority Administrator put these factors together, and the idea for a long term response was born. It was endorsed by the Board of Directors, who gave permission to have architectural drawings and cost estimates done. A home support agency endorsed the idea and developed a proposal and cost estimates to provide care services.

The idea has two stages.

Stage 1: The first stage involves converting one floor of one of the seniors' buildings to Assisted Living. The area would be residential in character and small in scale, and would provide a secure living environment to frail tenants needing assistance with everyday life.

The Housing Authority would pay for the physical conversion, and would lease the entire floor to the Chinook Regional Health Authority, which would sub-contract a home support agency to

deliver care to the tenants on this floor. The Housing Authority would not be stepping beyond its mandate into the arena of care and would not be liable for tenants living in this accommodation. Tenants would receive individualized care packages, which could include meals, housekeeping, laundry, nursing supervision (e.g. assistance with medications), and scheduling of outings and appointments.

The tenth floor of Leonard C. Halmrast Manor (one of the seniors' highrise buildings) is seen to be ideal for this conversion. It has 12 bachelor apartments, a one-bedroom apartment, and a large, L-shaped lounge (rarely used), which has an atrium and indoor garden overlooking the city. A laundry room off the bottom of the "L" has caused some plumbing problems in the building.

The bachelor apartments would be ideal for tenants needing support; the one-bedroom apartment which overlooks the entrance to the elevators could be used as overnight accommodation/office space for on-site care providers (with surveillance of the elevators); the laundry room could be converted to a re-heat kitchen from which meals could be served; the bottom of the L could be used as a dining area with four or more tables; and the lounge could be a communal area for activities. The laundry room would be relocated to the basement, where it would likely generate fewer plumbing problems.

Working drawings have already been done and cost calculations completed by an architect. The conversion, including relocation of the laundry room, can be done for less than $100,000, money which the Housing Authority has already saved and is willing to spend. They are not asking for any new money for this Stage 1 idea.

It has been estimated that the cost per tenant per month would be approximately $750: $300 for rent and $450 for the meal and light housekeeping package. Personal care provided through the Home Care program could be obtained for an average cost of $790/person/month (Home Care's ceiling for high need clients). These personal care costs would be covered by the Ministry of Health, through the Regional Health Authority, and are adjustable according to individual need.

The resident's cost would be similar to the Lodge program in Alberta, which provides hotel-type accommodation (shelter, meals and housekeeping) but no coordinated care.

The Lethbridge Housing Authority has estimated that the proposed arrangement could save significant amounts of public money, because of the efficiency of providing co-ordinated Home Care to residents who are all living in one location.

The Housing Authority would pay the one-time capital costs and on-going maintenance (e.g., repairs, decorating) as it would throughout the building.

It is planned that the modest conversion would take place soon and the few tenants who are currently occupying apartments on the tenth floor and who do not require care and supervision will be given incentives - for example, rental credit - to move elsewhere in the building. As each bachelor apartment becomes available, it would be redecorated and then outfitted to meet the individual needs of a tenant moving in - for example, grab bars may be added, and the stove may be removed. It is thought that other tenants in the building could take advantage of the meal service and activities. Referrals could also come from outside the building. Families of tenants would be involved in all aspects of decision-making as well as in developing care plans.

It is anticipated that this initiative would solve the problem of the increasing number of tenants needing supervision and support, reduce the problem of vacant bachelor apartments, and replace lost revenue within five years. The idea has the support of the Board of Directors, Housing Authority staff, and other providers in the Lethbridge network. It is also endorsed by those tenants who know about it.

One elderly woman who takes a bus across town every day to see her husband in a nursing home, said, "Maybe this way, couples could at least be in the same building!" Other tenants, who are natural helpers to their neighbours, see it as a sensible way to provide needed support within a familiar environment.

The Lethbridge Housing Authority would like to pilot this one-floor Assisted Living project, and evaluate it, before embarking on any more ambitious plans to support older tenants with dementia and other frailties. Indicators of success would likely be acceptance of the project by the community, family members and social/health networks; reduced duplication in home support services delivered to one building; fewer recorded disruptive incidents involving tenants with dementia (including incidents involving risk to self and others); reduced perceived burden among family members of tenants with dementia; increased levels of functioning for some tenants; and fewer vacant bachelor apartments and related revenue losses.

Stage 2: The longer term and more ambitious plan is to reconstruct the main floor of one of the seniors' buildings, add a commercial kitchen and dining room and offices for on-site personnel, and transform the entire building to Assisted Living.

4. Current Status

Neither Stage 1 nor Stage 2 has been implemented. Architectural drawings have been completed and initial cost estimates have been made. Support from providers in the community has been sought and achieved. There have been, however, numerous barriers to progress.

A proposal to provide some of the capital costs was submitted to the New Horizons Program of Health Canada and rejected. Approaches to the Alberta Ministry of Municipal Affairs have been met with some scepticism, since the Assisted Living initiative does not fit into any of the housing or care categories of the current provincial government, and it is the belief of some representatives of this Ministry that CMHC would never approve such a project. The Ministry has expressed openness to at least entertain the proposal, however, if it has the endorsement of the Regional Health Authority.

The Regional Health Authority, a potential partner in implementing the Assisted Living concept, has been so burdened by their workload during the process of regionalization of health care in Alberta that they have not been able to attend to this proposal from the Housing Authority.

It is hoped that the Ministry of Municipal Affairs will be able to approve a pilot project, and that this will be able to be implemented soon.

5. Analysis and Advice for Housing Providers

The Lethbridge Housing Authority takes responsibility for the quality of accommodation and the quality of life for their tenants. They do whatever they can do, within their mandate and their budget, to support their tenants to live independently in the community for as long as possible.

The advice they give to other municipal housing providers is:

- Know your tenants, know the community, and know how to convince others of what you know is needed, before going ahead with any initiative that requires outside support.
- Be visible to tenants and to providers so that your ideas have the support and trust of both parties.
- Don't hide behind 'We're just a landlord'. If this is your philosophy, go to the private sector.
- Remember that each building is a community within a community.
- Don't provide a list of rules tacked on a wall. This is the tenants' home!

In conclusion, representatives of the Lethbridge Housing Authority state:

> The true value of this supportive living concept is in the increased opportunity for residents to age in place, in an attractive environment that provides enhanced personal security with maximum choice. Couples would greatly benefit, especially in cases where one spouse must now travel to visit a spouse in a Lodge or Nursing Home. Cost benefits to the public purse are twofold: reduced Home Care expenses and improved revenues in social housing.

Case Study #2 -- Dufferin County Housing Authority

Organization

Dufferin County Housing Authority
Suite 9, 15 Brenda Boulevard
Orangeville, ON L9W 3L3

Contact

Janice Peters
Housing Manager
(519) 941-8221
(519) 941-9444 (FAX)

1. Context

The Dufferin County Housing Authority is a Local Housing Authority which acts as agents for the Ontario Housing Corporation to manage subsidized Ontario Housing Corporation buildings for seniors, single people and families living in Dufferin County. Although its primary focus is in the field of property management, it undertakes a number of activities to foster tenant relations.

Tenants' leases are with the Ontario Housing Corporation and come under the Landlord and Tenant Act.

In order to live in seniors only buildings, the applicant must be 60 or over and a legal resident of Canada. There are no financial requirements. However, tenants must declare their income each year, since rents are geared to their income.

The Housing Authority is responsible for 7 apartment buildings which house a total of 225 units for seniors and single people, as well as 8 semi-detached homes for families. It also provides 58 rent supplement units for families and single people in private accommodation throughout the county.

Two apartment buildings are designated for seniors only:

an 89 unit, three story building in Orangeville
a 60 unit, three story building in Shelburne

Five buildings contain a mix of seniors and singles:

12 units in a two story walk-up in Orangeville
10 units in a two story walk up in Orangeville
20 units in a two story walk-up in Shelburne
10 units in a one story building in Shelburne
16 units in a two story walk-up in Grand Valley.

The apartment buildings are located throughout the county, which is largely rural but growing rapidly (total population of approximately 40,000). The seven buildings which contain seniors are located in settled areas ranging in size from about to 1,600 in Grand Valley to 18,000 in Orangeville in the county's largest centre.

Approximately 95% of the Housing Authority's tenants are seniors (defined as 60 or over) with an average age of 75. Senior tenants are primarily female (estimated 85%), and range in health from quite fit to very frail.

Responsibility for project management and tenant welfare lies with the Housing Manager, who is assisted by two full time and one half time office staff. The Authority does not have a Community Relations Worker on staff.

Five of the seven buildings have caretakers who are on-site during normal working hours, five days a week. The two apartment buildings designated for seniors only have live-in caretakers. Although it is not in their formal job description, all caretakers are expected to be aware of tenant needs and inform the Housing Manager about tenants who are in crisis or may need extra assistance.

As well, all buildings have a security tenant, whose job is to deal with building emergencies when the caretaker is not on site and to complete a daily security check of the building (check that windows are locked, check that fire alarms are working, etc.) In some buildings, the security tenants have taken on additional responsibilities, such as driving tenants to medical appointments, informing the Housing Manager when tenants need additional services, and taking a tenant to the hospital during the night. Because these are not part of the job description, the extent to which the security tenant provides this kind of assistance depends on the particular individual who holds this position in the building.

The Housing Authority takes a community development approach to the way it does business, perhaps because the Housing Manager served as a Community Relations Worker with another Housing Authority before assuming her current position.

Their approach to tenant welfare reflects this community development orientation. Considerable effort has been devoted to working with tenants to identify their needs and preferences, and the ways in which these needs and preferences can be addressed. Through the Planning Together Committee (described in more detail below), tenants have expressed a desire to be involved in a number of issues relating to their own welfare. For example, the Housing Authority has facilitated the development of the Green Card Program, a security program in which floor captains check that participating tenants (participation is voluntary) have put their (green) card out at night, and taken it in in the morning.

The Housing Authority has also provided workshops and programs to help tenants understand how to respond when they have problems with a neighbour, and how to help others in the building. As a result of these initiatives, tenants have become concerned about the welfare of their fellow tenants, and a number of the tenants provide care to neighbours. In a tenant survey in October 1995, 50% of tenants reported helping others. In some cases this may consist of "keeping an eye on them", but some neighbours provide more specific help, such as bringing up their mail, helping them dress, and reminding them to take medications. In some cases they are said to provide care comparable in amount and type to that provided by Home Care --

assistance with bathing, dressing, shopping, cooking and similar activities. There is said to be an ethic relating to the need to help others as part of making the housing community a true community.

Partnerships and community collaboration are a strong component of the Housing Authority's approach to responding to tenants' needs. This is well captured by a comment by a member of the Housing Authority Board: "We are trying to provide Supportive Housing through tenant-community partners and the Housing Authority."

The Housing Authority works in partnership with many other agencies, including Meals on Wheels, Home Care (who purchase services from VON and other agencies in the community); the Psychogeriatric Unit of the Community Mental Health Clinic, and Dufferin County Support Services (a non-profit organization in which consumers pay for services, but may receive subsidies if they qualify).

The Housing Manager has good rapport with these service agencies. She often makes referral to these agencies and occasionally participates in case conferences.

Despite the effectiveness of the partnerships, the Housing Authority Board feels its work with community agencies could be expanded. It has explored the development of a Supportive Housing Program, described in detail later in the report. As well, a Board member suggested that the Housing Authority might work with additional partners in the future. For example, the police deal with tenants with dementia, especially finding and returning tenants who have wandered away from the building, and may be contacted by elderly tenants with complaints about their neighbours. Police need to be aware, educated and trained about how to deal with these kinds of situations.

A Board member suggested that other groups which provide services to seniors might also benefit from additional training, particularly on how to deal with tenants with dementia. Examples include providers of leisure services, such as the local Seniors Centre and members of the medical profession. Up-grading the dementia care skills of staff of agencies currently providing care to these residents was also suggested.

2. Tenants with Dementia

Staff estimate that at least 10%, and perhaps as many as 15%, of the 225 senior tenants have dementia, for an estimated range of 23 to 34 tenants. These tenants are to be found in all seven seniors buildings, and are not concentrated in one place within these buildings.

Although the Housing Authority is committed to enabling tenants with dementia to age in place for as long as is feasible, providing accommodation for these tenants can be a challenge, and is not without its risks for the tenant with dementia as well as for the other tenants.

In one instance, a tenant with serious delusions was a danger to herself and others. She wandered from the building on several occasions, at least once in her nightgown. The security tenant kept an eye on her and brought her back. She was not good about eating on her own, and there were concerns about her becoming malnourished. The Housing Manager often had to sit with her in her apartment in order to get her to eat.

Along with her functional difficulties, she also suffered from delusions. These delusions were often violent and involved being attacked or raped, or of being taken away. Sometimes, she would go out on her balcony to "escape her attackers". Often she would become disoriented and not be aware of where she was. Housing Authority staff were concerned that she might have a delusional episode while she was outside, and might fall or jump off the balcony in an attempt to escape her attackers.

Unfortunately, her family denied her diagnosis of dementia, and was not able to offer much help. Her son would come and spend the night with her, if called to do so, but felt his mother was managing all right and could continue to live on her own. It took six months for the Housing Authority to have her assessed and to arrange for her to move to more appropriate accommodation.

A more benign story was told by the caretaker. He explained that tenants often put large house plants on the balcony in the summer, and, because they were so large, put them in the corridor during the winter. A tenant with dementia approached him to say that she no longer wanted the plants she had left in the corridor, and asked him to assist her by disposing of them. He went to her floor, found the plants, and took them down to the garbage room, to be disposed of later. The following day, another tenant came to ask if he knew what had happened to her plants. They were large plants, and she left them in the corridor for the winter. That morning she had gone to water them, only to discover that they were not there. The caretaker took her to the garbage room, where she recognized her plants, and took them back to the floor with the assistance of the caretaker.

Although this second story had no serious repercussions, ended well, and would be seen as amusing by many, it illustrates the kinds of difficulties that can occur when there are tenants with dementia in the building. Their presence can be annoying to other tenants; one tenant reported having someone knock on her door in the middle of the night, though she simply ignores it. This same tenant expressed concern about having these tenants in the building. She feels anxious about them, and mentioned a recent fire in the building. Nevertheless, she is understanding and compassionate, and says she doesn't mind helping to look after them. "That's just the way it is. You wouldn't turn your back on them."

3. The Response

The key element in the Housing Authority's response is the Planning Together Committee. The original committee was founded in 1992 and consisted of ten people; as its name indicates, it was composed of residents (5 members), and community partners (3 representatives of community services, the Housing Authority Manager, and a member of the Board). There were two co-chairs, one a resident and one a community partner. In 1996, the committee consists of five residents and three community partners; there is only one chair, who is a resident.

The committee's role is to bring tenants together with community partners and the Housing Authority to identify joint ways of dealing with problems that housing communities are facing, and to celebrate success. It is hoped that in time tenants will come up with their own solutions, which is perceived to be a healthier response than "experts" telling them what to do. Networking, partnering, and information sharing are the important processes which contribute to the success of the committee's work.

A report from the Planning Together Committee states that "the actions the Committee saw as necessary support the validity of the community planning approach". As a result, the emphasis on community development is reflected in the overall strategy it has adopted to deal with the needs of tenants.

Although the strategy is not directed specifically towards tenants with dementia, and was not developed to deal with their unique needs, the approach does help these individuals to age in place longer than might otherwise be the case.

The strategy involves a collection of programs developed in response to issues which were raised by tenants. Some of these programs were already in place informally, but the Housing Manager felt they could be better implemented using a community development strategy. Moreover, this strategy would allow the Authority to respond to a greater number of tenant issues, since it would spread the work load beyond that of the Manager, who could not keep up with all the needs by herself.

Programs tend to fall into three major areas: tenant safety, tenant relations, and mental health.

Tenant safety programs include:

- "Green Card Program" -- floor captains check that tenants have put their green card out at night and have taken it in in the morning.

- a course in First Aid.

- a safety audit -- a speaker presented a workshop on home safety for housing tenants.

Programs in the field of tenant relations include:

- a tenant handbook -- this handbook is distributed to all new tenants. An orientation to the building and an introduction to other tenants, including the security tenant, is part of the moving in procedure.

- workshops on tenant relations -- These workshops help tenants understand what to do if there are problems with other tenants. Some workshops were initiated in response to specific concerns about tenants with problem behaviour (safety issues and acting out). The goal of the workshops was to reduce tenant anxiety about these behaviours, to help concerned tenants understand about these behaviours, and teach them some methods for helping tenants with problems. The programs were given by Public Health Nurses, and staff from Community Mental Health.

  The workshops broadened awareness and have helped tenants identify and be more comfortable with those with memory loss. As a result, there is more and more appropriate interaction between tenants with memory loss and those who are cognitively intact. In addition, the workshops have given tenants the message that the Housing Authority intends to keep cognitively impaired residents in their buildings for as long as possible.

- Senior to Senior Program -- This program has helped to increase tenants' awareness of and understanding of fellow tenants, and to be more responsive to their needs. Tenants who have participated in the program are more likely to reach out to memory impaired residents; for example, they may invite forgetful residents to come along with them to an activity taking place in the building. Tenants feel confident about how to manage these kinds of tenants/experiences, and if the encounter is successful, they feel encouraged and are willing to try it again.

In the field of mental health, activities consist primarily of workshops on topics such as managing bereavement, and mental health in general. Tenants played a significant role in identifying the need for many of these workshops.

4. Current Status

The Housing Authority continues to work with community partners to respond to the needs of tenants. Home Care has recently introduced a Flexible Care Program into some of the Housing Authority's larger buildings. In this program, two Home Care staff are assigned to a building and provide care to eligible clients within the building; previously, each client had their own Home Care worker, and there might have been as many different Home Care workers coming into the building as there were people receiving Home Care. The Flexible Care Program allows the Home Care workers to be more responsive to resident needs. Since they are in the building all day, workers can provide care when it is needed, and in smaller time periods than the normal two hour chunks. In addition, because the Home Care workers are in the building on an extended basis, they are able to identify other tenants who may require Home Care or other types of assistance.

The Planning Together Committee continues to meet and to generate ideas. Their recent efforts have been directed to preparing a proposal to develop their own model of Supportive Housing.

For its part, the Housing Authority has explored the possibility of providing Supportive Housing to assist tenants to age in place. In 1994, it submitted an application to the Ministry of Health for funding under the Supportive Housing Program. Under this program, additional services from community agencies would have been provided to tenants who required additional assistance to age in place.

Most Supportive Housing programs require tenants to live in units which are designated as part of the program. Since senior tenants of the Dufferin County Housing Authority are dispersed among seven different buildings, this approach would have required some tenants to move to another building where the designated units were located. To avoid this, the proposal was for modified Supportive Housing, in which a coordinated case management model would be used, to provide support while allowing tenants to remain in their current unit. The program would have provided a 24 hour emergency response system (a staff person would be on call) and flexible care. Under flexible care, tenants who require more than 60 hours of care a month (the designated limit under the Home Care program) would have been eligible for additional care. As well, care would have been provided to tenants who do not qualify for Home Care, but require more assistance than they are currently receiving. For example, a tenant with dementia might receive assistance with meal preparation to supplement the Meals on Wheels they were already receiving.

Although the Ministry found the program design acceptable, the application was turned down for technical reasons.

Since then, the Planning Together Committee has done a needs survey and is undertaking a new approach to developing Supportive Housing. Instead of submitting a proposal to the Ministry of Health, the Housing Authority, a community agency and the Planning Together Committee will work together to design a program. The major focus of the program is to enhance the service the agency is already providing to meet the needs of the housing community, and to do it in a way which will allow tenants to remain in their current accommodation. Consistent with the approach that tenants will play a significant role in planning for their own future, the details of this program are being worked out by the three participating groups.

Concern about the future of the Housing Authority's community development model has arisen as a result of the restructuring that is being planned for all provincial housing authorities in Ontario. This restructuring, which will take place within the next year to eighteen months, will see the Dufferin County Housing Authority amalgamated with the Housing Authorities for Muskoka and Simcoe County.

The greatest concern is with dilution of the local presence and thus diminished local accountability. The Board will be responsible for a wider geographic area, and there is concern about the future of the Planning Together Committee, since seniors would have to travel long distances to get to meetings. If staff changes occur, the Housing Authority Manager who has provided leadership for much of the community development strategy may not be available to preserve and strengthen what has been done.

Finally there is talk of privatizing the Ontario Housing Corporation, of which the Dufferin County Housing Authority is a part.

5. Analysis and Advice for Housing Providers

The Housing Authority's approach is well summarized in a quote from a member of the Board: "We are trying to provide Supportive Housing through tenant-community partners and the Housing Authority."

They offer the following specific advice to other housing providers:

- Learn as much as possible about the client group you are working with.
- Don't judge too quickly. Avoid stereotyping or jumping to conclusions about the meaning of tenants' behaviour.
- Seek as much support as possible from resources.
- Be responsive and flexible. Try to adjust to the needs, situations, policies and politics as they change.
- Nothing goes anywhere if tenants don't support it -- and if they aren't involved in the planning, they won't support it.

Although there are no formal evaluation criteria, the Housing Authority feels that their strategy has been a success. They cite anecdotal evidence to suggest the benefits of their approach.

"Participation is good, the turn-out is good when the Housing Manager attends a building for a consultation; more people are giving suggestions, it is not as hard to get information, and tenants feel more comfortable coming forward with respect to concerns about their neighbours. There is a better sense of community. New tenants participate, feel more welcome, and it is not the same people all the time. There is a greater sense of tenant ownership of problems. Tenants are more likely to say "This is what we are doing. Any other ideas." People no longer say "Janice, you handle it."

Case Study #3 -- Mont St-Hilaire

Organization

Office municipale de Mont St-Hilaire (OMH)
250, rue Radisson
Mont St-Hilaire
PQ J3H 2Z4

Contacts

Carole-Anne Lachaine
Director
Tel. (514) 464-3696

Francine Maltais
Social Worker
Centre Local de Services Communautaire
347 Durvernay
Beloeil J3G 5S8
Tel. (514) 536-2052

Raymond Poirier
Association des Services d'Aide Résidentielle (ASAR)
President
250 Radisson
Mont St-Hilaire
Tel. (514) 467-1970

1. Context

Mont St-Hilaire is a town of 13,000 residents approximately 35 kilometres from Montreal. It has grown in size in the last decade and is now considered part of the greater Montreal region. The Mont St-Hilaire Public Housing Authority has a total of 285 units in its 10 buildings.

The formal mandate of the Mont St-Hilaire Office municipale d'Habitation (OMH), as defined by the provincial government, is to provide subsidised housing to low-income residents, both seniors and families.

Nine of the ten buildings of the Mont St-Hilaire OMH are for tenants 50 and older. The tenth building, which has an elevator, is for persons 65 years or older. It is this building which contains the project for frail seniors which is the focus of this case study.

All tenants in OMH buildings must be independent and able to live without support, although a limited amount of help, such as house cleaning, is available from the local community health and social services centre (CLSC).

Residents in the nine buildings for people 50 and over range in age from 50 to almost 90 years old. The tenth building (which contains the project for frail seniors) has 44 units and is reserved for people 65 and over. The average age of its residents is 72; the percentage of women living in this building is higher than in the other buildings because of women's greater longevity and lower incomes.

Two approaches to tenant welfare are found within the Mont St-Hilaire OMH: that which applies to all residents and that for the project for frail seniors.

All buildings are inspected on a monthly basis by maintenance staff. Repairs are the responsibility of two staff members who take care of plumbing, electricity and carpentry while a third is responsible for janitorial services. The Director of the OMH visits buildings on a regular basis and upon request.

The OMH, with the CLSC, initiated a project which originally targeted fostering 'good neighbouring' to encourage residents to get to know each other. This evolved into a formal tenants association which represents their interests to the administration.

The frail seniors project has been implemented in the tenth building to help more dependent seniors continue to age in place. A *ressource support* (Support Worker(s) -- currently it is a married couple) lives in the building and is responsible for providing specific assistance to the seniors participating in the project. Participants in the frail seniors project are older; the average age is 78. Only two of the eight current participants are male. The project serves a maximum of nine residents in the building. The small number of participants allows support to be geared to individual needs and helps create the "family" feeling that is a goal of the project.

One apartment in the building is reserved for the couple employed as the Support Worker(s) while another apartment is used for meal preparation and as a dining area (service apartment).

The Support Worker(s) sees participants daily while serving the two meals (lunch and dinner) that she is responsible for cooking and serving. She routinely visits apartments for weekly house-cleaning and laundry, as well as to deliver food and sundries. The Support Worker(s) is available twenty-four hours a day, seven days a week.

The Social Worker from the CLSC visits participants in their units once a month, while the OMH staff see participants a minimum of four times a month.

Each participant in the project signs a contract with the Support Worker(s) outlining the responsibilities of each. The participant agrees to

- pay a monthly charge at the beginning of each month;
- have lunch and supper in the service apartment;
- inform the Support Worker(s) of any long absence from the service; and
- provide a one month notice if he or she wishes to leave the project(unless the person is moving to a hospital or long-term care facility).

The Support Worker(s) agrees to

- provide two well-balanced and varied meals a day;
- provide afternoon and evening snacks for participants to take to their units;
- purchase breakfast food and home care products (e.g., toiletries and cleaning products) for participants;
- assure that they (or a substitute) are available 24 hours a day, 7 days a week;
- accompany participants on outside visits (e.g., to a doctor) if they require this assistance and no other resource is available; and
- provide weekly house-cleaning and laundry.

The Support Worker(s) can administer medications if needed. This medication is kept in the service apartment and given at meals or two containers are given at supper, one with the evening dose and the other with the morning dose, depending on the requirements. Support in budgeting and paying bills can be offered, although the Support Worker(s) is not to manage the participants' money directly. Depending on availability, transportation services are offered, priced according to distance (e.g., a return trip in Mont St-Hilaire is $3, to Montreal, $15). If a person has been ill or hospitalised, meals may be brought to their apartment for up to a week, although this can be extended if there is indication of improvement on the part of the participant. Friends and family may come for meals for a minimal price ($3.50).

The project requires close supervision on the part of the ASAR Board. For example, the Support Worker(s) gives them monthly menus, and weekly spot checks are made to make sure that the quality of the food is high and that the menu is being respected. The Social Worker from the CLSC makes monthly visits to the participant's apartment, which allows for verification that supplies and services are maintained. Close contact with the residents is another way of monitoring the project.

Given that meals are the focal point of the 'family', they take on a great importance and participants will complain to administrators or neighbours (who will contact the OMH) if they don't like what is being served. There was a period when food was of low quality and monotonous. At the height of the problem, the project had only two participants, the others having left because of the quality of the meals.

Information gathered during the initial assessment is kept confidential, but information about nutrition or other special needs is shared with the Support Worker(s). The participant is asked for permission to share this information with the Support Worker(s) and this information is given to the Support Worker(s) in the presence of the participant.

Each case is reviewed with the Support Worker(s) during the formal monthly ASAR Board meeting. (Participants are aware of this.) Difficult cases or situations are discussed and suggestions and new approaches are proposed. The tenant representative on the ASAR Board has access to information which might be 'circulating' on an informal basis among residents. If pertinent, this information is brought to the ASAR Board meetings. The Support Worker(s) is obliged contractually to inform the CLSC of any problems with the participants (physical or mental) or of any changes in the situation of participants which could have an impact on them (e.g., a death or illness in the family).

2. Tenants with Dementia

Fewer than 10% of OMH residents are said to have problems related to dementia but these are not assessed as severe; the OMH cannot maintain residents whose condition is too advanced because of the lack of sufficient supervision. In the project for frail seniors, the CLSC assesses the senior before he or she is accepted into the project. The person must be able to live autonomously and the support required must be limited to meal preparation, house-cleaning, laundry, and administration of medication. If the level of care needed is beyond what is available in the project (e.g., the person cannot take meals collectively) they will be asked to move to a facility offering greater care.

Administrators believe that the structured group situation of the project has allowed participants to remain independent longer. For example, one resident spent 25 years in institutions because of his epilepsy. When mass de-institutionalisation began in the 1980s he moved to the OMH and received support from the CLSC. He became a participant in the project when this support was no longer sufficient. He has said that to move back into an institution would result in his death -- even a short-term hospital stay is difficult for him. The administrators are convinced that he would not have survived the last three years were it not for the project for frail seniors.

Participants in the project live throughout the building, in the same unit they have always occupied. If the participant has problems which may endanger themselves or others, such as forgetting to turn off the stove, the OMH intervenes (e.g., by unplugging or removing the stove). Other situations have required intervention. For example, when one participant left their water taps on, the neighbour below got in touch with the OMH and the taps were turned off. (No serious damage was done.) The participant was continuously reminded, by the Support Worker(s) and residents, to turn the taps off; this was done in a gentle and humorous manner. Sometimes participants are convinced that they have been robbed. The Support Worker tries to calm them down and find the object -- often it was misplaced or forgotten. The monthly Board meetings are key in developing new and appropriate responses to problems that arise.

3. The Response

As both the OMH and the CLSC became aware of increased needs of an aging population in the public housing sector, it became clear that the level of care required by frail residents was beyond what the OMH and the CLSC were able to offer and that a more constant level of support was needed if residents were to remain at home. The two organizations formed a non-profit organization, the Association des Services d'Aide Résidentielle (ASAR). The three-member ASAR Board of Directors is composed of a representative from the CLSC, one from the OMH and an OMH resident. The mandate is to develop residential help (i.e., address the needs of a group of seniors in a building rather than individuals). The mandate is not exclusive to public housing; eventually services could be offered to groups living in co-ops or other non-profit housing.

In 1993 the provincial government developed a policy framework to support frail seniors in public housing. Although this policy was implemented at the same time as the Mont St-Hilaire project, the OMH and the CLSC had begun discussions two years before. The OMH

had presented a project to the Société d'habitation du Québec (SHQ, the Quebec Housing Corporation) but it had been turned down. The level of commitment to the project was such that the Director of the OMH and the Social Worker from the CLSC were going to go ahead on a voluntary basis. The Ministry of Social Services was interested in this kind of partnership with the Ministry of Municipal Affairs (responsible for housing) and supported the efforts of the Mont St-Hilaire organisations. The formal policy and the project emerged almost simultaneously.

When the project was announced to residents of the OMH seniors building, there was fear that their building would become a nursing home. This did not last long; residents now realize that the project is to their advantage. They too will be able to stay in their units longer because additional support is available if needed. Since the Support Worker lives in the building, all residents feel more secure -- they know that they can call on them in case of emergency. (The Support Worker then contacts either the OMH or the CLSC to advise them of the problem.)

Although other options exist in the town for seniors, the ones offering care in an autonomous environment are expensive whereas the clientele of public housing have limited financial means. Furthermore, residents would have to move out of their units, something they avoid as long as possible.

According to the members of the ASAR Board, the key to the project's success is the choice of the Support Worker(s). The project is in its third year of operation and with its third Support Worker(s). The problems with the first two were attributable to a lack of precision in defining the qualifications and personal qualities required. For example, cooking skills are very important. (One couple was heavily criticised for not providing good meals. The person responsible was learning to cook on the job.) The importance of "people skills" was underlined. The couple that is currently employed have ten years of experience running a home for handicapped people. The wife is capable of providing meals for large numbers and enjoys it while the husband takes care of the laundry, cleaning and transportation. Two people are necessary to carry out the work. As well, a family with children is not suitable as a Support Worker since the building is populated exclusively by older persons making cohabitation difficult for the children (e.g., isolation) and the residents (e.g., noise).

Monthly ASAR Board meetings and the support of the CLSC Social Worker are key in dealing with people with dementia. The services offered give the participant with dementia a structure to their day as well as social interaction. Safety is assured by eliminating the need to cook or to self-administer medication.

Participants in the project pay $532 a month, to cover the cost of the food, sundry items and services. If there are fewer than nine participants in the project, the Support Worker is paid $165/month for each vacancy. Depending on the participant's level of income, a subsidy might be required to cover costs. The subsidy is based on the amount left after rent (a monthly average of $250) and the support services ($532). If less than $220 a month remains, a subsidy is given.

The OMH provides a support apartment where meals are prepared and served, a monthly rental loss of $300. The rent for the apartment where the Support Worker lives is $300/month, services included, which is below market rent in the area.

One of the issues that surfaced after the project was initiated was that of time off for the Support Worker(s). Initially only 36 days a year were foreseen but this proved to be too few. The Support Worker(s) now has two days off a week but they are responsible for finding a replacement. A yearly maximum of $1,200 is given to the Support Worker(s) upon monthly presentation of invoices to cover this cost. The issue of vacation has not yet been dealt with since the current Support Worker(s) has been employed less than a year. Undoubtedly this will represent a further cost increase.

The total cost of the project is $19,600 a year. The OMH portion is $3,600 in lost rental revenue for the service apartment. The CLSC covers the cost of the subsidy and the Support Worker(s) (time off, vacancies, etc.); $16,000 a year. However, it was pointed out that there is probably almost no net cost to the CLSC, since they do not have to give other support services, such as house-cleaning, to the participants.

4. Current Status

The project is almost three years old. Major changes have revolved around the needs of the Support Worker(s) (more time off) and their qualifications (people skills, food preparation). The project is unique in the province of Québec although a similar one has begun in St-Hyacinthe, a neighbouring municipality to Mont St-Hilaire). There are also other similar examples in Drumonville and Loretteville, and other municipalities have also expressed interest.

5. Analysis and Advice for Housing Providers

The project has been recognised by the region and received a prize. Members of the ASAR Board feel the most significant indicator of success is the number of requests they have received to set up similar projects in other buildings and housing projects. The project's reputation has grown throughout the community and among residents of the OMH.

The greatest obstacle for the ASAR was finding the appropriate Support Worker(s) -- persons who could give support, provide good meals and meet the other obligations to participants. ASAR Board members feel that if they were to start again, they would define the qualities required for the Support Worker(s) differently to avoid all the problems they have experienced to date. However, they also recognize that this was part of the learning curve and perhaps was inevitable.

Another obstacle has been integration of new participants. An adjustment period is required for group living. One participant experienced difficulties for over six months. The Support Worker(s) tried different methods to deal with her (following suggestions offered during the monthly meetings of the ASAR Board). The participant's difficulties and the problems she was creating in the group were discussed with her. (She was very critical of the project and was arousing dissatisfaction among the other participants.) She seems to have accepted that she must adjust to stay in the project.

The ASAR would like to expand the service to other housing projects but current financial limitations do not allow this. No plans to expand or modify this project are foreseen. The

project was not designed for advanced stages of dementia and will not be changed to accommodate greater levels of support. When it becomes clear that a participant can no longer function within the framework of the project, a formal assessment is undertaken by the CLSC and the person is placed in a more suitable institution.

According to the Board, the key factors for success are

- collaboration between the agencies;
- the right Support Worker(s);
- viability and constant support from the agencies to the Support Worker(s);
- knowledge of the milieu; and
- a concentration and minimal number of persons requiring support.

6. Conclusion

ASAR Board members emphasized that this project not only offers social and physical support in a 'family' atmosphere, but that this is done at minimal cost. Beyond improving the quality of life of seniors, this project is, in some cases, extending it.

Case Study #4 -- Yarmouth Regional Housing Authority

Organization

Yarmouth Regional Housing Authority
206-368 Main Street
Yarmouth, NS
B5A 1E9
Tel. (902) 742-4369
Fax: (902) 749-1258

Contacts

Kim Jacquard
Tenant/Community Relations Worker

Ruth Anderson
Field Officer

Gerard Cheeke
General Manager

1. Context

Senior applicants with low or fixed incomes who cannot afford rents currently charged in the private sector, or who can no longer afford to own a home, may apply to the Housing Authority for decent affordable, apartment accommodation.

The population of the Town of Yarmouth is 7,781; the County area served by the Housing Authority has a population of 28,562. In 1995, 6,690 residents of Yarmouth County (23.4%) were over the age of 55. While demand for seniors housing has declined in the Western Region of Nova Scotia, a fairly long waiting list for seniors housing still exists in the Yarmouth County area. Currently, 340 seniors reside in 306 senior citizen housing units in all three areas served by the Housing Authority. The largest building has 36 and smaller buildings range from 15 to 17 units.

In recognition of the fact that there are currently seniors and disabled people in housing units both within the Authority portfolio and in private accommodation who require more assistance and support than is currently available in the Yarmouth area, the Yarmouth Regional Housing Authority, the Nova Scotia Department of Housing and Municipal Affairs and the Yarmouth Argyle Home Care Services have entered into an agreement to provide a supportive living environment. Supportive Housing is available to all eligible Housing Authority tenants, new applicants and private residents in the Town of Yarmouth, as well as Yarmouth and Argyle municipalities.

The main goal of this supportive living environment is to assist in maintaining and extending independent living while reducing the necessity for higher levels of care and transfer to an institutional setting. According to the Housing Authority brochure provided to prospective residents, "Supportive Housing offers attendant services linked by modern communication

techniques... providing minimal support services on a 24-hour basis..." No other on-site arrangements such as this are contained within the seniors housing portfolio maintained by the Housing Authority. The only exception would be individual seniors who have requested Home Care nursing and housekeeping services independently.

To be eligible for Supportive Housing, a person must qualify for Senior Citizens Accommodation through the Yarmouth Regional Housing Authority. A point-score system is used to determine the condition of their current accommodation and scores rate the presence of stairs, overcrowding, health factors, evidence of disrepair and inadequate or unsafe heating systems. Income, shelter cost and assets are also rated. The principal tenant must be at least 58 years of age or older, though younger people may be accepted under special circumstances (e.g., if they have a physical disability).

Tenant selection is made first by a staff admissions committee following the Housing Authority's point score system. Potential Supportive Housing residents are identified according to "greatest need" as defined by staff as well as independent assessments of health status and assistance needed with daily living. Residents of Supportive Housing must have needs which can be met by Yarmouth Argyle Home Care Services, the VON and through the core support services offered on site. These residents come from within the Housing Authority portfolio as well as from the urban and rural areas in the county.

Opened in January 1995, the Supportive Housing residence was developed as a separate 17-unit building, newly constructed for seniors in a suburban area of the Town of Yarmouth about 2.5 kilometres from downtown. This building has three levels with one fully accessible entrance, a verandah and large windows providing a good view of the surrounding park land and rural landscape. Another Housing Authority seniors building is located nearby as are emergency services and hospital facilities.

A few months before the final construction phase was completed for this building, a joint-proposal was made to municipal council by the Housing Authority and Yarmouth Argyle Home Care Services for modification of the building's occupancy to include residents who require delivery of health and social services as well as some degree of on-site surveillance. It was decided by both the Housing Authority and Home Care that there was a clear need for housing for residents requiring several different services including monitoring of medications and housekeeping. This residence would offer a higher level of contact with Home Care by having someone live on-site, providing a sense of what residents and family interviewed labelled as the psychological aspects of personal security: "At least I know someone is there, even if I don't see her every day."

Twenty residents live in 16 units and one of the units is occupied by a trained visiting homemaker. She serves as the live-in Resident Manager who provides the Housing Authority's contracted Supportive Housing services during the evenings and weekends. She is on-call and can be paged 24 hours a day should her services be needed. Each resident has her pager number, although some find it hard to follow the two-step telephone connection procedure. Every other weekend and during holidays, another homemaker stays in the building.

During the day, a package of services is provided by visiting homemakers, Home Care nurses, meals-on-wheels and additional services such as grocery deliveries, foot care, hair

dressing and transportation. All tenants receive light housekeeping assistance. This package of services serves as the weekday coverage of Supportive Housing needs until the live-in Resident Manager formally comes on duty in the late afternoon.

As defined by the Housing Authority eligibility criteria, there are 18 seniors in this building: 14 singles living alone and two couples. Seventeen women and three men live in Mountain View Manor, about half of whom are over 80 years of age. This building has one single male resident who meets the eligibility criteria at age 39 and a single female resident who is 48. Both these residents have multiple health and mobility problems, and the female resident experiences frequent hospitalizations.

2. Tenants with Dementia

According to Housing Authority staff, "about six of the residents show some early signs of dementia which have been either formally diagnosed and are being monitored by health professionals." A few more of the residents are occasionally forgetful or confused which may be attributed to medications or recent personal trauma due to death of a spouse.

The Resident Manager lives in an apartment facing the back of the building and was recently alerted to the fact that the street and the front grounds of the building were flooded. She reported: "a resident with a good view of the street called me early in the morning and said the basement level of the building which has residents might be flooded. I quickly knocked on all of the doors to start evacuation of the basement apartments and assisted with one confused resident by asking her sister, also her next door neighbour, to contact her personally. Still she was reluctant to leave her apartment." She explained that a back-up system using neighbours with some confused residents is extremely important.

At least one of the residents with mobility restrictions and some forgetfulness who was interviewed described a typical day and what she ate which was very characteristic of the "tea and toast" syndrome described by dieticians. She used her toaster all the time and was setting off her heat sensor and smoke alarm in the kitchen.

Approximately 12 residents are frail with physical disabilities due to arthritis or other causes and several of these residents have multiple health problems requiring daily insulin intake and/or supervised drug protocols. Several residents of the building are related to each other; this results in the added benefit of family social supports which provide companionship, transportation, running errands and preparing meals for the more frail residents.

3. The Response

The Resident Manager provides assistance for emergency situations that may arise after hours and on weekends. As directed, she helps residents assessed with critical health needs according to the local Home Care agency, those who have requested surveillance themselves or follows requests from their family members. She also routinely conducts checks when notified any resident is ill or convalescing from hospitalization. The Resident Manager is also responsible for building security (closing doors and windows and locking up), filing requests for maintenance repairs and passing on complaints to the Housing Authority.

The Housing Authority maintenance staff visit the building once a week to clean the laundry rooms, lounge and hallways. All the residents interviewed mentioned how clean and spotless the building was and the family members said this added to the pride their parents felt about living there. Grounds crews also clean up the parking lot and the surrounding landscaping. A few residents took the initiative to plant two flower beds which they also maintain on their own and the Housing Authority provides an allowance to cover their costs.

During the weekday, individual housing-related services are provided as needed by the Housing Authority, Community Relations Worker and the Field Officer. The community relations worker is responsible for ensuring that objectives of the facility are being met in terms of housing services, security, Home Care and other supportive services. Because "everyone has housekeeping assistance and it is not an option," there is less concern about residents falling behind in personal hygiene and taking care of their apartment units. This is light housekeeping assistance, however, and some concern has been expressed about who will do the heavy work such as cleaning the fridge, the stove and the windows. There is some concern that the provincial government may limit the frequency of once-a-week housekeeping services in the future.

The field officer handles the application process, payment of rent and fees as well as conducting the at-home housing/living assessments. The fees include a $25 a month surcharge to cover the cost of the Resident Manager. She is also responsible for doing housing assessments during the residents' tenancy and has had two cases recently of move-outs -- one for disruption of the other tenants and neglect in the unit (not related directly to dementia); and the second because the resident was not happy and could be looked after better by a family member in their home.

On average, each staff member and the general manager visit the building twice a month. The field officer says she seems to be in this building almost once a week. Special meetings to explain rules and procedures such as the fire evacuation plan and changes in Supportive Housing arrangements are held with residents. These meetings may be initiated by the Resident Manager or by the Housing Authority staff. So far, about four meetings have been held each year. Residents mentioned that attending these meetings is optional and some don't bother to go because people complain a lot. The fire evacuation meetings have required attendance, however.

To date, no group meetings have been held with family members. Both the community relations officer and the field officer will meet individually with family members at any time and often take telephone calls. Similarly, the Resident Manager will check in and report back to family who have made routine requests for surveillance or reassurance checks, especially to accommodate family members who do not live in the area.

Few planned social activities take place in this building. There are informal groups that gather in the (now, smoke-free) lounge, but attempts to organize games and crafts classes have not worked out very well since the building opened. The Christmas party including family members was organized by the Resident Manager and her assistant. Several residents mentioned they enjoyed this event which was the "highlight of the year." The regular pattern of card games, pot-luck meals and teas characteristic of social activities in other seniors' buildings has not happened here according to the community relations officer.

Residents may arrange to have a visiting nurse from the health department, VON home nursing care delivered and other needed supportive services as directed by the Home Care agency. Disabled residents who already used VON services before moving to the facility have continued to use these services. Another common service provided by the VON has been pre-loading syringes for daily insulin injections, though other arrangements are now being made for this service. The Resident Manager, Home Care or housing staff may also report on residents who are becoming socially isolated, exhibiting signs of confusion such as entering the wrong floor or apartment, and who show lack of personal care or inadequate eating habits and nutrition.

If because of illness or particular bad periods, residents need live-in caregiving either by family members (or a paid caregiver), arrangements can be made for temporary stay in this residence as long as this stay does not involve an extended period of tenancy. There is no on-site suite in the building to serve as temporary accommodation. All of the residents seem to have couches that can make into an extra bed and several mentioned having children or grandchildren staying with them especially when they were ill or settling in.

Given the information provided by staff, residents and family who were interviewed, it seems the main source of supportive service partnerships still remains with the family. Each of the three daughters interviewed (including one daughter who commutes from another province) still see themselves as having almost daily contact with their mothers. One daughter and her family felt her mother was not relying on them enough, while the other daughter was hoping that after a year in the residence her mother might rely on them less. The daughter who lives away feels she is still on-call and worries about the progressive state of her mother's deterioration after having been diagnosed with Alzheimer's disease.

Regular meetings are coordinated by the community relations worker, with the field officer, the Resident Manager and the director of the Home Care agency. The current focus of these joint meetings is not the day-to-day operations and tenant satisfaction, but problem-solving. If a resident's tenancy needs to be reassessed because of personal safety concerns, serious illness which hampers their ability to perform self care and independence or functioning problems causing disruptions for other residents, then meetings are held to review each individual case. A new set of housing services and Home Care assessments would be made at this time.

4. Current Status

Now that the building will be two years old in January, the General Manager and Housing Authority staff are discussing the need for a formal evaluation of the housing units, Supportive Housing services and role of the Resident Manager. While many of the residents interviewed felt fairly positive about the residence, a few had suggestions for some large and small changes which would improve the building itself, the housekeeping arrangements and access to Home Care services when needed.

With evaluation research that involves all of the residents and their family members, and more outreach and follow-up regarding individual needs and concerns, the Housing Authority staff and the Home Care agency expect improvements in their first attempt at anticipating needs and delivering Supportive Housing services. "As you can see from the waiting list, we

already have a good start on filling a second building if we had one." Currently, there are several people who qualify for Supportive Housing on the waiting list. Four singles and one couple are from within the Housing Authority portfolio and three singles and one couple from the community are also on the waiting list, creating a total demand for nine Supportive Housing units. There are no expected vacancies in the building at this time, although unlike other seniors housing where residents tend to stay for longer periods of time, it is anticipated that tenure may be shorter in this building, given some tenants' age, cognitive functioning and health status.

Currently there are concerns about cuts to individual coverage of Home Care services in the province and the case load in each region is being reassessed. However, the Housing Authority feels confident that the concept of Supportive Housing will not change, nor will the services decrease. Cuts in house cleaning has caused some stress and concern for residents, but some are dealing with this by hiring privately to take care of their needs.

No formal evaluation procedure is in place to assess the performance and satisfaction with the role and assigned duties of the Resident Manager. Similarly, while the Resident Manager's duties are explained along with the objectives of the Supportive Housing arrangements on a page appended to the back of the tenancy lease, there appears to be some ambiguity in the understanding of the Resident Manager's on-site responsibility to conduct surveillance only in the evenings and on weekends. Some family members had expected regular daily checks on their parents without having to make a request. One resident who appears to be somewhat isolated said "This is such a small place you would think she might wonder where I am." Several people wondered what would happen if they really became confused or their parent started to wander. The Resident Manager claims that she keeps informal tabs on people, but does not want to intrude unless she is formally asked to do so.

Personal security was rated as the main reason for living in this residence by the five residents and three family members interviewed. All the residents said they are better off in Mountain View Manor than where they were living before, although some miss their friends and neighbours, especially in the other Housing Authority seniors' buildings. However, one there is some ambiguity about the extent of support to be provided at this site, as a result of the Housing Authority's intentions to provide "minimal support services" and the reality of circumstances faced by residents with limited mobility, serious health and/or cognitive functioning problems.

5. Analysis and Advice for Housing Providers

The Nova Scotia Ministry of Housing and Municipal Affairs is quite interested in this project as an alternative model to the provincial Enriched Housing Program. The Yarmouth Regional Housing Authority feels they have launched a unique experiment which exhibits a larger commitment to extending the independence and quality of life for its residents. "On bad days, we ask ourselves should we be in this business," according to the General Manager. By being involved in Supportive Housing services, the Housing Authority has pushed their mandate into new areas. On the other hand, they know that many of their existing older residents are in their 80s and eventually there will be fewer spaces in the already somewhat limited special care facilities in Yarmouth County.

Their advice to other municipal housing providers is

- Make sure the roles are clear between the Housing Authority and the Home Care agency.
- Ensure there is good oversight of the actual delivery of on-site attendant supportive services and other Home Care services.
- Don't confine services to seniors using criteria of chronological age. There are a lot of women in their 50s with financial needs and health problems.
- Make your residence visible so it is part of the housing stock in the neighbourhood and not just labelled as an institutional facility.
- Make the family members partners in these services as much as the residents, the Housing Authority, the Home Care agency and other related services.

Summary of Case Studies

The four case studies describe four quite different approaches used by municipal housing providers to respond to the needs of tenants with dementia. Despite differing approaches some common themes do emerge.

1. None of these initiatives was developed specifically to deal with tenants with dementia. Although each of these initiatives makes it possible for tenants with dementia to continue living in the community longer than might otherwise be the case, none of them was developed exclusively to meet the needs of this tenant group. This strongly suggests that existing programs designed to promote aging in place can be adapted to respond to the needs of tenants with dementia. It is hoped that this finding will encourage other housing providers to review their existing programs to identify how they can promote aging in place for tenants with dementia.

   That the same program seems to work well for tenants with dementia as well as those who are cognitively intact clearly offers a financial advantage. Where there are few tenants with dementia, it would not be cost-effective to develop a separate program. However, since these tenants can be served by the same programs used for the cognitively intact, the cost per resident will be lower than if two separate programs were required. Integrating these residents into programs for the cognitively intact means that support can be provided to tenants with dementia even when there are too few of them to justify a separate program.

2. All the programs responded to individual circumstances. No single approach will be appropriate for all housing providers. Each of the four Housing Authorities responded to a unique situation in their community. The need to be aware of the context within which the housing provider is working is reflected in the advice given by each of the four provider agencies, and is well summed up by some of the advice offered by the Housing Manager of the Dufferin County Housing Authority's advice:

   > "Learn as much as possible about the client group you are working with."

In order to be successful, the program must fit with the needs, preferences, abilities and life-styles of the tenants who are being served. This is reflected in the advice from the Lethbridge Housing Authority:

> "Know your tenants, know the community, and know how to convince others of what you know is needed, before going ahead with any initiative that requires outside support."

3. The Housing Authorities took advantage of opportunities as they presented themselves. With the possible exception of the OMH in Mont St-Hilaire, the schemes were developed in response to opportunities which presented themselves. For example, the Lethbridge Housing Authority's scheme evolved in response to the difficulty they were experiencing in renting bachelor units, while the schemes in Mont St-Hilaire and Yarmouth took advantage of funds provided by a new provincial program (though Mont St-Hilaire had planned the program before the funds were available). The Dufferin County Housing Authority applied for funding from the province's Supportive Housing Program when those funds become available.

4. Successful programming requires persistence and flexibility. Although persistence and flexibility are important for the successful development of any type of program, these case studies offer ample evidence of their importance. Both the Lethbridge Housing Authority and the Dufferin County Housing Authority have made multiple efforts to achieve their goals. When the province declined to fund the somewhat unconventional approach to Supportive Housing developed by the Dufferin County Housing Authority, the Authority revised its strategy and has sought funding from a different source. The Lethbridge Housing Authority has approached several different potential funders in its effort to implement their project.

   In Mont St-Hilaire, the OMH and the CLSC have also made changes to the program as necessary. These include changes in the staff, and in the qualifications for staff, as well as recognizing the need to provide additional time off for the Resource Person.

   The Dufferin County Housing Authority advises:

   > "Be responsive and flexible. Try to adjust to the needs, situations, policies and politics as they change."

None of the three existing projects (the project in Lethbridge has not been implemented as of this writing) has undergone a formal evaluation, but anecdotal evidence from all three suggests these programs are rather successful. It is hoped that the positive experience of these three programs will encourage other housing providers to develop programs to allow older tenants to age in place.

Although these programs were not designed specifically for tenants with dementia, the experiences of municipal housing providers in Mont St-Hilaire, Dufferin County and Yarmouth indicate that programs to promote aging in place help all seniors, regardless of their cognitive status. The projected increase in the number of older adults with dementia, combined with the decreased number of long-term care beds, means that municipal housing will be home to a growing number of such tenants, whether housing providers plan for them

or not. Planning to meet their needs will improve the quality of life for tenants who are cognitively intact as well as those with dementia. It will also ease the job of Housing Authority staff and Board, as well as community service providers who are an important component of community living for the elderly.

Discussion

The results of this study suggest that much needs to be done to enable municipal housing organizations to respond to the presence of tenants with dementia. The case studies describe some specific responses that some housing providers have taken. This section contains a discussion of some general themes and issues which emerged from the study, particularly with respect to the survey data.

Although responses to the survey, particularly the open ended questions, suggest that providers have a wide variety of needs and problems, a more careful consideration of the study results suggests that the responses to the study findings fall into four major categories.

- Educate housing providers about the nature of the problem. Although just over half the survey respondents reported having one or more tenants with dementia, few appeared to have developed a systemic response to the problem. Among those who reported not having any residents with dementia, the most striking pattern is that there is little evidence that these respondents are thinking ahead about a problem which is likely to arise in the future. Housing providers need to be made aware of the projected prevalence of dementia and of the increasing probability that their buildings will be home to a growing number of people with these disorders.

- Encourage housing providers to develop a plan to respond to this situation. Once housing providers are aware of the problem, they need to plan a response. Responding to individual cases will prolong the time the resident can remain in the housing, but a more comprehensive approach will help the provider develop a response which balances the needs and rights of the resident with dementia against those of other residents and their families, as well as housing staff and administration. A more comprehensive approach to planning will also allow housing providers to consider how to provide for the safety of all tenants within the constraints imposed by the existing structure, financial constraints, and the organization's mandate. Such a plan could also provide guidance about when a person with dementia would need to move to a higher level of care. In turn, this would assist family caregivers in their own long term planning for care of their relative.

- Help housing providers get the information, education and training they require about dementia and dementia care. When respondents were asked about what they need to know to deal with a growing number of tenants with dementia in their housing, they said that, first and foremost, they need to know about dementia -- its signs, its stages, its consequences, the needs of people with this illness, how to manage tenants with dementia, and at what stage these special tenants must be placed in a long-term care facility for their own and for other tenants' safety. They also need to know who to go to (and where) for help -- they want names and telephone numbers. Finally, they need to know how to make their buildings safe and secure for their tenants with dementia and for the other tenants. Education and training are called for.

- Ensure that staff of the agencies they work with have the information and skills to provide good dementia care. Since the most common response to having tenants with dementia was to work with other agencies, it is important to ensure that agency staff

are able to provide quality dementia care. Although staff at many of the agencies will already be versed in this area, there will be exceptions.

Strategic Considerations

As housing providers develop a response to the growing presence of tenants with dementia, they will have to balance a number of complex factors. Some of these are discussed briefly below.

- An Issue of Equity. A strategy for accommodating residents with dementia will need to address the question of whose needs are to be met and which perspectives will be incorporated into the response. The strategy must respond in an equitable and balanced manner to the needs of residents with dementia and the non-impaired. Both these groups have the right to a safe and secure environment which facilitates, to the maximum level possible, their ability to function independently and to have a good quality of life.

  The response should consider all residents' right to age in place, to remain in their own homes (i.e., the units they are living in) for as long as possible. Although it is important to meet the needs of residents with dementia, this must be tempered by the recognition that municipal housing should not "become a nursing home". This concern about adapting buildings and services to the point that the housing becomes a long-term care facility was expressed by several respondents, and is a legitimate concern of housing providers, housing staff, other residents and their families.

  In part this concern has to do with the self-image of non-demented residents, who may feel concerned about their own future in the face of the cognitive deterioration of their neighbours. Research in long-term care settings indicates that cognitively well elderly have made it clear they do not want to spend their lives with people who are cognitively impaired.

  The results of this study indicate that cognitively impaired residents of municipal housing may engage in activities which are disturbing to their neighbours (for example, making noise, knocking on their door, entering the neighbours' apartments). The potential for caregiver burnout exists if non-demented tenants are expected to provide care for those with dementia or otherwise assume responsibility for their well-being.

  As well, it is important to ensure that municipal housing continues to attract new residents, who have both the right and the need to take advantage of this kind of living. If municipal housing is perceived to have become a community living facility for people with dementia, cognitively intact residents will no longer wish to move there.

- Legislative and Regulatory Barriers. A number of respondents referred to the legislative and regulatory barriers to responding to the presence of tenants with dementia. The most frequently mentioned was the mandate of the housing provider, and the question of whether its role was to provide shelter ("bricks and mortar") or whether its mandate also includes the provision of services. This issue, which often

involves other levels of government, needs to be given consideration in planning a response.

Another factor which must be dealt with is an individual's right to refuse assistance. This difficult issue is not unique to the question of how to respond to tenants with dementia in municipal housing, but it also needs to be addressed in any strategy which is developed.

- Funding Sources. Responding to the presence of tenants with dementia will involve additional costs, and costs were the most frequently mentioned barrier to making changes. This raises the question of who will pay for additional services, a particularly thorny issue in a time of increasing financial restraint.

  Each housing provider will have to arrive at its own resolution of where the increased funding will come from. To the extent that this is viewed as a provincial, as opposed to local, issue, discussions should take place between the ministry responsible for health and the ministry responsible for housing in each province.

  A number of arguments can be made that the provincial ministries responsible for health should provide funding towards programs which will help residents with dementia remain longer in municipal housing. The simplest of these arguments has to do with the relative budgets of the ministries responsible for housing and those responsible for health. In every province, the budget of the ministry responsible for health far exceeds the budget of the ministry responsible for housing. Furthermore, if residents with dementia were forced to move from municipal housing to a long term care setting, the cost of caring for them would increase significantly, a cost which would then be paid in full by the ministry responsible for health. As well, where people with dementia live in municipal housing and receive Home Care, the money spent on specific programs for them could be found through a reallocation of some existing home care expenditures to fund these dementia-specific programs. Indeed, this might represent a more efficient use of existing resources, which would allow increased numbers of residents with dementia to benefit from the same number of dollars.

Final Notes

The aging of the population, combined with policies to promote aging in place, means that municipal housing will be home to a growing number of tenants with dementia. A survey of municipal housing providers has highlighted the need to develop systemic approaches to respond to this situation. A review of major themes in the data suggest some important roles for Alzheimer organizations in assisting housing providers to meet the needs of residents with dementia.

Long term responses to the situation must achieve a balance between the needs of residents with dementia and those who are cognitively intact. The response must also recognize the presence of legislative and regulatory barriers to housing residents with dementia, as well as funding implications. Although these factors represent significant challenges to developing a long term response, they should not be viewed as preventing a successful resolution to the question of how to meet the needs of older residents with dementia in municipal housing.

End Notes

1. Design for Health Unit, Institutional and Professional Services Division. (1991). Designing Facilities for People with Dementia. Ottawa: Health and Welfare Canada.

2. Cluff, Pamela J. (1990). Alzheimer's disease and the institution: Issues in environmental design. The American Journal of Alzheimer's Care and Related Disorders & Research, 5(3), May/June 1990, 23-32.

3. Calkins, Margaret P. (1988). Design for Dementia: Planning Environments for the Elderly and the Confused. Owings Mills, Maryland: National Health Publishing.

4. Gnaedinger, N. (1989). Housing Alzheimer's Disease at Home. CMHC Research Report, CMHC National Office, Ottawa.

5. CMHC. (1990) At Home with Alzheimer Disease: Useful Adaptations to the Home Environment.

6. Zgola, J. (1990). Alzheimer's disease and the home: Issues in environmental design. The American Journal of Alzheimer's Care and Related Disorders & Research, 5(3), May/June 1990, 15-22.

7. To some extent this question assumes that the respondent is knowledgeable enough about dementia to know whether there are residents with dementia living in the building. However, this study was not necessarily concerned with medically confirmed diagnoses, but rather with people who may show the typical symptoms of dementia. It is this distinction which accounts for the somewhat unusual wording of this question.

APPENDIX A

RESEARCH MATERIALS:

QUESTIONNAIRE, COVER LETTER

AND FOLLOW UP LETTER

For each question, please circle the number after your response or write in your answer where appropriate. Please return the completed questionnaire by June 14, 1995 to Myra Schiff Consultants Limited, Suite 213, 110 Richmond Street East, Toronto, ON M5C 2P9.

1. In which province is your housing organization located? ______________________

2. What kind of geographic area is your housing organization responsible for? *(Please circle all that apply.)*

   urban 1 suburban 2 rural 3

3. How many buildings is your organization responsible for? ___ buildings

4. How many residential units is your organization responsible for? ___ units

5. How many tenants live in your residential units? ___ tenants

   5a. How many of your tenants are seniors (people 55 years of age or older)?

   ___ seniors *(If none of your tenants are seniors, it is NOT necessary for you to answer any additional questions. Please return the questionnaire in the enclosed envelope. Thank you for your assistance.)*

6. What is your practice about mixing seniors and non-seniors in the same building(s)? *(Please circle the number in front of the answer which best describes your approach.)*

   1 All our tenants are seniors (55 years of age or older).

   2 All senior tenants live in "seniors-only" buildings.

   3 Some buildings are for seniors only and some are for seniors and other tenants.

   4 All our buildings have a mix of seniors and younger tenants.

   5 Other arrangement *(please describe)*

7. Are you aware of any senior tenants in your buildings who have, appear to have, or are said to have dementia (such as Alzheimer Disease)?

   Yes 1 No 2 *(If NO, please skip to Question 10.)*

   7a. How many of these seniors do you estimate there are in your buildings? ___

7b. Do these residents live in "seniors-only" buildings or in buildings with other tenants?

1 All are in "seniors-only" buildings.

2 All are in buildings with seniors and other tenants.

3 Some are in "seniors-only" buildings and some are in buildings with other tenants.

7c. From what source did you learn that they had a form of dementia? (*Please circle all that apply.*)

1 Tenants' association

2 Social Club

3 Another tenant or tenants

4 Visiting homemaker, nurse or other paid home care provider

5 Tenant's family

6 Housing staff *(Please specify -- e.g., administrator, cleaning staff, building maintenance)*

____

7 Other *(Please specify)* ______________________________

8. Have any of these tenants ever done anything to make you feel concerned about their living in one of your buildings?

No 1 (*If NO, please skip to Question 10.*)

Yes 2 (*Please give examples.*)

9. What did your housing organization do to respond to your concerns about these particular individuals? (*Please describe.*)

10. The table below lists some strategies which might be effective in responding to the needs of tenants with dementia living in your housing. For each strategy, please put an X in the box which most accurately describes your organization's current position on that strategy.

Strategy	Have Implemented This	Planning to Implement	Have Considered	Not Considered
1. develop a new policy				
2. change an existing policy				
3. make physical changes to our building(s)				
4. provide education and training for staff and administration				
5. increase our staff				
6. work with other agencies				

10a. Please elaborate on any of the activities you have implemented or are planning to implement. *(Please be as specific as possible. Use an additional sheet of paper if necessary.)*

10b. We would like to know how effective each of the strategies listed in Question 10 has been in **promoting the safety of tenants with dementia in your building(s).** In the chart below, please circle the number which best describes how successful you think each of these activities has been.

1 = Very Effective
2 = Effective
3 = Not Sure
4 = Not Too Effective
5 = Not At All Effective
X = Not Applicable, Haven't Done This

Developed a new policy	1	2	3	4	5	X
Changed an existing policy	1	2	3	4	5	X
Physical changes to building(s)	1	2	3	4	5	X
Education and training for staff and administration	1	2	3	4	5	X
Increased staff	1	2	3	4	5	X
Work with other agencies	1	2	3	4	5	X

10c. Please rate the same six strategies from Question 10 with respect to how effective each of these activities has been in **promoting the safety of other tenants in buildings which also contain residents with dementia.** In the chart below, please circle the number which best describes how successful you think each of these activities has been.

1 = Very Effective
2 = Effective
3 = Not Sure
4 = Not Too Effective
5 = Not At All Effective
X = Not Applicable, Haven't Done This

Developed a new policy	1	2	3	4	5	X
Changed an existing policy	1	2	3	4	5	X
Physical changes to building(s)	1	2	3	4	5	X
Education and training for staff and administration	1	2	3	4	5	X
Increased staff	1	2	3	4	5	X
Work with other agencies	1	2	3	4	5	X

10d. Please describe any other strategies or procedures you have implemented to respond to tenants with dementia in your housing.

11. Listed below are possible objectives you might consider when planning how to respond to the needs of tenants with dementia. For each objective, please circle the number which best describes how important it has been, is, or is likely to be in helping you decide what actions to take.

1 = Very Important
2 = Important
3 = Not Sure
4 = Not Too Important
5 = Not At All Important

Enhancing the safety of the tenant with dementia	1	2	3	4	5
Helping the person with dementia to live independently	1	2	3	4	5
Increasing the length of time the tenant with dementia can remain in your housing	1	2	3	4	5
Enhancing the safety of other tenants	1	2	3	4	5
Reducing stress for other tenants	1	2	3	4	5
Increasing staff's and administration's comfort with tenants with dementia	1	2	3	4	5
Increasing staff's and administration's ability to manage disruptive incidents successfully	1	2	3	4	5

12. In general, what kinds of changes to social housing for seniors do you think would be most effective in helping you accommodate tenants with dementia in the future?

    12a. What do you see as the barriers to implementing these changes?

13. What suggestions or advice would you give to other social housing providers who have older tenants with dementia?

14. What community or non-profit organizations, agencies or government departments would you find it helpful to consult or collaborate with to enable you to respond to the needs of tenants with dementia?

    14a. What could they do to help you maintain tenants with dementia in your housing?

15. What do you think are the most important things social housing providers need to know to address the problem of an increasing number of tenants with dementia living in their housing?

THANK YOU FOR YOUR COOPERATION AND ASSISTANCE!

Myra Schiff Consultants Limited

213, 110 Richmond Street East
Toronto, ON M5C 2P9
Tel. (416) 360-8200
Fax (416) 360-1207

Planning environments and services for older adults

DATE

Mr. John Jones
Manager, This City Housing Authority
123 Main Street
This City, Province

Dear Mr. Jones,

Canada's population is aging. Funding limitations mean there are fewer long-term care beds. As a result, more people with Alzheimer Disease and related dementias are living in the community. Canada Mortgage and Housing Corporation (CMHC) has funded me to study how social housing providers are responding to this situation.

Your name was randomly chosen from a list of housing providers in Province to participate in this study. The enclosed questionnaire should take about fifteen minutes to complete. However, to ensure the accuracy and completeness of your responses, you may wish to consult with other members of your organization, including front line staff, when answering some of these questions. Please return the completed questionnaire in the envelope provided by June 14.

Your replies are completely confidential. Your questionnaire will be combined with those of other respondents and will be used for statistical purposes only. The number on the first page of the questionnaire is a unique participation number, for which only I hold the key. After I have analyzed the survey results and found respondents from whom I would like further information, I will use the participation number to know who to contact.

The report for CMHC will contain recommendations to help housing providers respond to the growing numbers of people with Alzheimer Disease and related dementias living in social housing. Please write, call me (416 360-8200) or fax me (416 360-1207) if you have any questions. Thank you for helping with this important project.

Sincerely yours,

MYRA SCHIFF CONSULTANTS LIMITED

Myra R. Schiff, Ph.D.
President

Survey: Adapting Housing for Dementia

Last week we mailed you a questionnaire on Adapting Housing for Dementia. If you have already returned the completed questionnaire, please accept our sincere thanks. If not, please complete it as soon as possible. Your response is important to help us an accurate picture of how housing providers are responding to the needs of senior tenants with dementia.

If you did not receive the questionnaire, or if it has been misplaced, please call me right now, collect, at (416) 360-8200 or fax me at (416) 360-1207 and we will mail you another one at once.

Thank you for your cooperation.

Myra Schiff

Pour chaque question, veuillez encercler le numéro correspondant à votre réponse selon le cas. Remplir et retourner le questionnaire avant le 29 juin 1995 à l'adresse suivante : Myra Schiff Consultants Limited, Suite 213, 110 Richmond Street East, Toronto, ON M5C 2P9.

1. Dans quelle province se trouve votre organisation immobilière ?
   ____

2. Votre organisation immobilière est responsable de quel type d'environnement géographique ? (Veuillez encercler toutes les bonnes réponses.)

   urbain 1 banlieue 2 rural 3

3. Votre organisation est responsable de combien d'immeubles ? ______ immeubles

4. Votre organisation est responsable de combien d'unités résidentielles ? ______ unités

5. Combien de locataires vivent dans vos unités résidentielles ? _______ locataires

   5a. Parmi vos locataires, combien y-a-t-il de personnes âgées? (personnes de 55 ans et plus) ?

   ____ personnes âgées *(s'il n'y a aucune personne âgée parmi vos locataires, il n'est pas nécessaire de poursuivre. Veuillez retourner le questionnaire dans l'enveloppe ci-jointe. Nous vous remercions de votre collaboration.)*

6. Quelle est votre pratique en ce qui a trait à l'intégration dans le(s) même(s) immeuble(s) des personnes âgées et des plus jeunes ? (Veuillez encercler le numéro qui correspond le mieux à votre manière d'aborder la question.)

   1. Tous nos locataires sont des personnes âgées (55 ans et plus).

   2. Tous les locataires âgés vivent dans des immeubles « pour personnes âgées seulement ».

   3. Certains immeubles sont réservés aux personnes âgées et d'autres sont ouverts aussi bien aux personnes âgées qu'à d'autres locataires.

   4. Tous nos immeubles abritent aussi bien des locataires âgés que des plus jeunes.

   5. Autres arrangements *(veuillez décrire).*

7. Savez-vous si certains de vos locataires âgés sont atteints, semblent être atteints ou passent pour être atteints de démence (telle la maladie d'Alzheimer) ?

oui 1 non 2 (dans la négative, veuillez passer à la question 10.)

7a. À votre avis, combien y a-t-il de ces personnes âgées dans vos immeubles ?

______

7b. Ces résidents vivent-ils dans des immeubles « pour personnes âgées seulement » ou dans des immeubles abritant également d'autres locataires ?

1. Tous vivent dans des immeubles « pour personnes âgées seulement ».

2. Tous vivent dans des immeubles abritant aussi bien des locataires âgés que des plus jeunes.

3. Certains vivent dans des immeubles pour « personnes âgées seulement » et d'autres dans des immeubles abritant également des locataires plus jeunes.

7c. De quelle source avez-vous appris que ces locataires souffraient de démence ? *(Veuillez encercler <u>toutes</u> les bonnes réponses.)*

1. Association des locataires.

2. Club social.

3. Autre(s) locataire(s)

4. Auxiliaire familiale, infirmière ou autre prestateur de soins à domicile

5. La famille du locataire

6. Personnel de l'immeuble *(veuillez préciser—administrateur, responsable du ménage, personnel d'entretien)*

____

7. Autre *(veuillez préciser)* ______________________________

8. Vous êtes-vous déjà inquiété de la présence dans vos immeubles de certains de ces locataires ?

Non 1 *(dans la négative passez à la question 10)*

Oui 2 *(veuillez donner des exemples)*

9. De quelle façon votre organisation immobilière a-t-elle répondu à vos préoccupations en ce qui a trait à ces locataires ? (Veuillez en donner la description.)

10. Le tableau ci-dessous dresse la liste de certaines stratégies qui pourraient être efficaces afin de répondre aux besoins des locataires atteints de démence et vivant dans vos immeubles. Veuillez inscrire un X dans la case qui décrit le plus fidèlement la position actuelle de votre organisation immobilière au sujet de chacune de ces stratégies.

Stratégie	Mise en pratique	Prévoit mettre en pratique	Idée considérée	Jamais considérée
mettre en place une nouvelle règle de conduite				
modifier une pratique existante				
procéder à des rénovations sur notre ou nos immeubles				
offrir des services d'éducation et de formation au personnel et à l'administration				
augmenter notre personnel				
collaborer avec d'autres agences				

10a. Veuillez élaborer sur toutes les mesures prises ou que vous prévoyez prendre . *(Veuillez préciser le plus possible. Utilisez une feuille supplémentaire au besoin.)*

10b. Nous aimerions en savoir plus long sur l'efficacité de chacune des stratégies énumérées à la question 10 en ce qui a trait à la **promotion de la sécurité des locataires atteints de démence dans votre ou vos immeubles.** Dans le tableau ci-dessous, veuillez encercler le numéro qui correspond le mieux, selon vous, aux résultats de chacune de ces stratégies.

1 = très efficace
2 = efficace
3 = ne pourrait dire avec certitude
4 = pas très efficace
5 = pas efficace du tout
X = sans objet; cette mesure n'a pas été prise

mettre en place une nouvelle règle de conduite	1	2	3	4	5	X
modifier une pratique existante	1	2	3	4	5	X
procéder à des rénovations sur notre ou nos immeubles	1	2	3	4	5	X
offrir des services d'éducation et de formation au personnel et à l'administration	1	2	3	4	5	X
augmenter notre personnel	1	2	3	4	5	X
collaborer avec d'autres agences	1	2	3	4	5	X

10c. Veuillez évaluer les mêmes six stratégies de la question 10 en ce qui a trait à l'efficacité de chacune de celles-ci dans la **promotion de la sécurité des autres locataires dans les immeubles qui abritent également des personnes atteintes de démence.** Dans le tableau ci-dessous, veuillez encercler le numéro qui correspond le mieux, selon vous, aux résultats de chacune de ces stratégies.

1 = très efficace
2 = efficace
3 = ne pourrait dire avec certitude
4 = pas très efficace
5 = pas efficace du tout
X = sans objet; cette mesure n'a pas été prise

mettre en place une nouvelle règle de conduite	1	2	3	4	5	X
modifier une pratique existante	1	2	3	4	5	X
procéder à des rénovations sur notre ou nos immeubles	1	2	3	4	5	X
offrir des services d'éducation et de formation au personnel et à l'administration	1	2	3	4	5	X
augmenter notre personnel	1	2	3	4	5	X
collaborer avec d'autres agences	1	2	3	4	5	X

10d. Veuillez décrire toutes les autres stratégies ou mesures prises afin de répondre aux besoins des locataires atteints de démence dans vos immeubles.

11. La liste ci-dessous propose des objectifs possibles pouvant vous aider à planifier les façons de répondre aux besoins des locataires atteints de démence. Dans votre choix des actions à prendre, veuillez encercler le numéro qui correspond le mieux à l'importance que vous avez accordée, que vous accordez ou que vous accorderez probablement à chacun de ces objectifs .

1 = très important
2 = important
3 = pas certain
4 = pas très important
5 = pas du tout important

Promouvoir la sécurité du locataire atteint de démence	1	2	3	4	5
Aider la personne atteinte de démence à vivre de manière autonome	1	2	3	4	5
Prolonger la période de temps pendant laquelle le locataire atteint de démence pourra vivre dans votre immeuble	1	2	3	4	5
Promouvoir la sécurité des autres locataires	1	2	3	4	5
Réduire le stress des autres locataires	1	2	3	4	5
Soulager le fardeau du personnel et de l'administration face aux locataires atteints de démence	1	2	3	4	5
Aider le personnel et l'administration à mieux faire face aux incidents perturbateurs.	1	2	3	4	5

12. De manière générale, quelles sortes de changements aux logements sociaux pour personnes âgées seraient les plus efficaces, selon vous, pour vous aider à répondre aux besoins des locataires atteints de démence dans l'avenir ?

12a. Quels obstacles voyez-vous à la mise en application de ces changements ?

13. Quelles suggestions ou conseils aimeriez-vous donner aux autres fournisseurs de logements sociaux qui ont des locataires âgés atteints de démence ?

14. Quelles associations communautaires ou à but non lucratif, agences ou services gouvernementaux aimeriez-vous consulter, ou avec qui vous aimeriez collaborer, afin de vous permettre de répondre aux besoins des locataires atteints de démence ?

14a. Comment pourraient-ils vous aider à garder dans vos immeubles les locataires atteints de démence ?

15. Selon vous, quels sont les choses les plus importantes que les fournisseurs de logements sociaux doivent savoir de manière à répondre aux problèmes occasionnés par le nombre croissant de locataires atteints de démence vivant dans leurs immeubles ?

Nous vous remercions de votre coopération !

Myra Schiff Consultants Limited

213, 110 Richmond Street East
Toronto, ON M5C 2P9
Tel. (416) 360-8200
Fax (416) 360-1207

Planning environments and services for older adults

Le 7 juin 1995

Monsieur Henri Bouchard directeur
OMH DE VILLE
123, rue Principale
Ville, PQ

Monsieur,

La population canadienne vieillit. Les compressions budgétaires entraînent une réduction du nombre de lits réservés aux soins de longue durée. En conséquence, un nombre croissant de personnes atteintes de la maladie d'Alzheimer et de démences connexes vivent dans la communauté. La Société canadienne d'hypothèques et de logement (S.C.H.L.) m'a demandé d'étudier la façon dont les gestionnaires de logements sociaux répondent à cette situation.

Votre nom a été choisi au hasard à partir de la liste des offices municipaux d'habitation du Québec afin de participer à cette enquête. Cela devrait vous prendre environ 15 minutes pour répondre au questionnaire. Cependant, de manière à donner une réponse précise et détaillée à certaines des questions, vous voudrez peut-être consulter les autres membres de votre organisation, y compris le personnel qui a un contact direct avec les locataires. Veuillez remplir et retourner le questionnaire avant le 21 juin.

Vos réponses resteront confidentielles. Votre questionnaire et celui des autres personnes interrogées seront utilisés à des fins statistiques seulement. Le numéro imprimé sur la première page est un numéro de participation unique dont je suis la seule à détenir la clé. Une fois que j'aurai analysé les résultats de l'enquête, j'utiliserai ce numéro de participation si je désire obtenir de plus amples informations auprès de certaines des personnes interrogées.

Le rapport de la S.C.H.L. contiendra des recommandations qui aideront les gestionnaires de logements sociaux à répondre aux besoins des locataires atteints de la maladie d'Alzheimer et de démences connexes, dont le nombre grandit sans cesse. Si vous avez des questions, il suffit de m'écrire, de m'appeler au (416) 360-8200 ou de m'envoyer une télécopie au (416) 360-1207. Je vous remercie de collaborer à cet important projet.

Veuillez agréer, Monsieur, l'expression de mes sentiments distingués.

MYRA SCHIFF CONSULTANTS LIMITED

Myra R. Schiff, Ph.D.
présidente

Enquête : Adapter le logement aux besoins des personnes démentes

La semaine dernière, nous vous avons envoyé un questionnaire portant sur le logement et les besoins des personnes démentes. Si vous avez déjà rempli et retourné le questionnaire, nous vous remercions beaucoup. Sinon, nous vous prions de le faire le plus tôt possible. Vos réponses nous aideront à nous faire une idée plus juste sur la façon dont les gestionnaires de logements répondent aux besoins des personnes atteintes de démence.

Si vous n'avez pas reçu le questionnaire, ou s'il a été perdu, veuillez nous appeler aussitôt que possible à frais virés au (416) 360-8200, ou nous télécopier vos coordonnées au (416) 360-1207, et nous vous en enverrons un autre immédiatement.

Nous vous remercions de votre coopération.

Myra Schiff