RESEARCH REPORT

HOUSING OPTIONS FOR ELDERLY OR CHRONICALLY ILL SHELTER USERS

CMHC SCHL

HOME TO CANADIANS

Canada

CMHC—HOME TO CANADIANS

Canada Mortgage and Housing Corporation (CMHC) is the Government of Canada's national housing agency. We help Canadians gain access to a wide choice of quality, affordable homes.

Our mortgage loan insurance program has helped many Canadians realize their dream of owning a home. We provide financial assistance to help Canadians most in need to gain access to safe, affordable housing. Through our research, we encourage innovation in housing design and technology, community planning, housing choice and finance. We also work in partnership with industry and other Team Canada members to sell Canadian products and expertise in foreign markets, thereby creating jobs for Canadians here at home.

We offer a wide variety of information products to consumers and the housing industry to help them make informed purchasing and business decisions. With Canada's most comprehensive selection of information about housing and homes, we are Canada's largest publisher of housing information.

In everything that we do, we are helping to improve the quality of life for Canadians in communities across this country. We are helping Canadians live in safe, secure homes. CMHC is home to Canadians.

Canadians can easily access our information through retail outlets and CMHC's regional offices.

You can also reach us by phone at 1 800 668-2642
(outside Canada call (613) 748-2003)
By fax at 1 800 245-9274
(outside Canada (613) 748-2016)

To reach us online, visit our home page at www.cmhc-schl.gc.ca

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.

HOUSING OPTIONS FOR
ELDERLY OR CHRONICALLY ILL SHELTER USERS

CMHC C.R. File No. 6530-62

FINAL REPORT

Submitted to:

Anna Lenk
Research Division
Canada Mortgage and Housing Corporation
National Office
700 Montreal Road
Ottawa ON K1A 0P7

By:

Luba Serge
Housing Consultant
3668 de Mentana
Montréal QC H2L 3R3

And

Nancy Gnaedinger
Consultant in Gerontology
2705 Arbutus Road
Victoria BC V8N 1W8

June 23, 2003

Executive Summary

This national study for Canada Mortgage and Housing Corporation is an exploration of problems and solutions related to elderly and chronically ill shelter users.

The central research questions to guide the study were:

- Why are elderly people and chronically ill persons living in shelters for homeless people?
- What are their residential long-term care needs?
- What are the barriers to their accessing long-term care, and how can these barriers be reduced or removed?
- What strategies have been developed in Canada to address the needs of this population?

The study was undertaken in three phases. First, an international literature review and an exploratory survey of professional networks were conducted to identify fundamental issues. Second, key informant interviews were carried out with long-term care providers, placement co-ordination service providers, emergency shelter providers, and long-term care providers within the emergency shelter system. Third, 13 case studies that respond to the needs of elderly and chronically ill shelter users were completed.

For this research, absolute, literal or visible homelessness was the basis of the definition of “homeless”, while “elderly” was defined as persons 50 years and over.

The findings of this exploratory study echo much of what is found in literature on homelessness from other countries: there is a paucity of studies on elderly homelessness; elderly homeless persons are quite vulnerable, especially from younger homeless persons; while many elderly homeless persons are homeless only once and for a short duration, others are chronically homeless and maintaining permanent housing may be of considerable difficulty for this group. The literature on health care and homelessness underlines the difficulty in providing adequate and constant care as well as the consequences of this problem: premature ageing among homeless persons and a greater likelihood of dying from preventable causes.

Interviews with key informants from the long-term care and homelessness sectors reveal that they experience similar challenges: the supply does not meet the need – whether it is the need for shelters, transitional housing or residential long-term care. The interviews also made it clear that information on elderly, homeless women in particular is scarce or undocumented. Furthermore, while many shelters are barrier-free, some remain inaccessible to persons with mobility problems and, if personal care is required, most shelters cannot accommodate

the need. Finally, it is clear that lack of co-ordination and integration of health services and shelters is an issue of considerable concern, especially discharge planning for homeless patients leaving hospitals: such integration is still in its infancy in many cities.

Findings from the 13 case studies confirm what was learned from key informant interviews. For example, the integration of health and shelter services is nascent in Canada. As well, few examples of an integrated approach between shelters and mainstream long-term care facilities were found. Most residential projects documented in this study were developed by shelter providers. This approach raises a number of questions including how to protect the more vulnerable elderly homeless persons from younger, possibly predatory shelter users and what the ideal settings for residential projects for elderly homeless persons should be: the city core with its close proximity to services or outlying areas, away from dangerous situations.

The case studies demonstrate that support from governments at all levels; inter-sectoral and inter-disciplinary collaboration, and a community-development approach are keys to success providing housing options for elderly or chronically ill shelter users who need care.

Despite the development and delivery of the solutions reported in this document, the needs of elderly and chronically ill homeless people in Canada are still largely unmet. Most of the facilities documented in this study have waiting lists. Service providers stated that even if the number of places they can offer were doubled or tripled, the need would still be unmet.

Table of Contents

1. Introduction 5

2. Research Methods 6

2.1 Data Collection Methods 6
2.2 Definitions 7

3. Key Informant Interview Findings 9

3.1 Elderly Homeless Persons 9
3.2 Chronically Ill And Disabled Homeless Persons 10
3.2 Access To Residential Long-Term Care For The General Population 12
3.3 Access To Residential Care For Homeless Persons 13
3.4 Supports Needed To Accommodate Homeless Clients 15
3.5 Mainstream Residential Care Facilities 16
3.6 Long-Term Care Strategies For Elderly Or Chronically Ill Homeless Persons 19
3.7 Ideal Residential Care Facilities For Elderly, Chronically Homeless Persons. 20

4. Case Studies: A Summary Of Findings 23

5. Summary Of Findings And Conclusions 27

6. Suggestions For Further Research 31

Appendix A: Literature Review 33

Appendix B: Bibliography 58

Appendix C: Key Informant Interview Guides 64

Appendix D: List Of Key Informants 69

Appendix E: Detailed Case Studies 72

Case Study #1 Hospice For The Homeless The Mission, Ottawa, Ontario 73
Case Study #2: Seaton House Infirmary, Toronto, Ontario 76
Case Study #3: Integration Of Health And Shelter, Toronto, Ontario 78
Case Study #4: Hazelton Residence – Vancouver, Bc 80
Case Study #5: Proposed Transition Housing Project For Aboriginal People With Mobility Disabilities, Winnipeg, Manitoba 83
Case Study #6 : Résidence Du Vieux Port, Montreal, Quebec 85
Case Study#7 : Maison Claire Ménard Montreal, Quebec 88
Case #8: Birchmount Residence Toronto, Ontario 90
Case Study #9: Legion Wing - Prince George, Bc 94
Case Study #10: Veterans' Memorial Manor – Vancouver Bc 97
Case Study #11: Former Integrated Program, Oak Bay Lodge – Victoria Bc 100
Case Study #12: Fairway Woods -- Victoria Bc 103
Case Study #13: Pioneer Inn – Whitehorse, Yk 105

Appendix F: Case Study Questions 107

1. INTRODUCTION

This national study for Canada Mortgage and Housing Corporation (CMHC) is an exploration of problems and solutions related to elderly and chronically ill shelter users who need care.

The central research questions to guide the study were these:

- Why are elderly people and chronically ill persons living in shelters for homeless people?
- What are their residential long-term care needs?
- What are the barriers to their accessing long-term care and how can these barriers be reduced or removed?
- What strategies have been developed in Canada to address the needs of this population?

Research was carried out between September 2002 and June 2003.

This document reports the findings from the exploratory study in six chapters and six appendices. Chapter 2, to follow, gives the definitions underlying the study and describes the research methods used. Chapter 3 reports the findings from interviews with key informants across Canada. Chapter 4 is a summary of the findings from 13 case studies conducted in five regions of Canada. Chapters 5 and 6 include conclusions and suggestions for further research.

Appendices contain: A) Literature Review, B) Bibliography, C) Key Informants' Interview Guide, D) List of Key Informants, E) Case Studies, and F) Case Study Questions.

2. RESEARCH METHODS

2.1 Data Collection Methods

The study was undertaken in three phases. First, an international literature review and an informal, exploratory survey of professional networks across Canada were conducted to identify fundamental issues. Another purpose of the informal survey was to find key informants for both in-depth interviews and potential case studies.

Second, over 20 in-depth, key informant interviews were carried out with long-term care providers, placement co-ordination service providers, emergency shelter providers, and long-term care providers within the emergency shelter system. The scope of this phase of research was limited to five areas of Canada (Quebec, Ontario, Manitoba, British Columbia, and Yukon) with more detailed data collection conducted in Quebec, Ontario, and British Columbia than the other jurisdictions.

Key informants were identified through references in the literature and by using a "snowball" method -- that is, asking key informants to identify others in their own, or a related, field. They were all asked general overview questions, such as the situation in their region in terms of the availability of shelters or long-term residential care beds, as appropriate. Long-term care providers were asked about the process of providing community-based health services to elderly or chronically ill homeless people and the criteria and challenges of placing them in residential care. They were also asked to provide examples of assessment forms, to clarify the criteria for placement in residential care. Shelter providers were asked about the situation of, and options for, this group of homeless people who need support and care.

Third, 13 case studies of projects that respond to the needs of elderly and chronically ill shelter users were completed. These 13 initiatives, a convenience

sample, were identified during the first two phases of research. (Because it was found during the second phase of research that examples of a formalized "integration approach" are almost non-existent, all but one of the case studies fall into the category of "segregated" solutions.) Information was gathered by telephone, email, and fax interviews and enriched by researchers' site visits to eight of the projects.

It should be mentioned that the study was originally designed to include only six case studies. During early phases of research, however, it became increasingly clear that responses to this population's special needs are recent and rare in Canada; new information and lessons learned from case studies are needed and highly valued by service providers and policy makers alike. It was decided, therefore, to double the number of case studies in order to increase both the range of information and amount of inspiration for persons concerned with this population.

2.2 Definitions

As in most research dealing with homelessness, defining "homeless" was one of the initial tasks. Furthermore, because homelessness has considerable impact on health and individual ageing, the definition of "elderly" needed review.

Homeless and Homelessness

For this research, absolute, literal or visible homelessness was the definition used for "homeless". This includes living on the street, in temporary shelters or in locations not meant for human habitation. Absolute homelessness can be chronic or short term: at one extreme it is a prolonged or repeated state which homeless persons move in and out of constantly throughout their lives; at the other extreme, it is a temporary situation which never re-occurs. Another facet of the definition of homeless is that many persons who have been chronically homeless are hard-to-house due to various factors, including personal

characteristics, the impact of life on the streets on their behaviours, or "shelterisation" (i.e. the institutionalisation that may result from hostel living).

Elderly

The literature indicates a growing consensus that "elderly" among the homeless population refers to persons aged 50+ (Bruckner, 2001; Hamel, 2001; Cohen, 1999; Cohen et al, 1997). There are various reasons for this.

- At 50, homeless persons look and act 10-20 years older (Cohen, 1999).
- Stresses, nutritional problems, and untreated health conditions contribute to premature ageing (Hawes, 1999).
- The experience of homelessness results in premature ageing (Bruckner 2001; Hamel 2001).
- Life expectancy for homeless persons is much lower (Crane 2001; Eberle et al. 2001).

The informal survey conducted during the first phase of research confirmed this definition of elderly. It was pointed out that there are people even younger than 50 who have the physical characteristics (such as poor liver function and vitamin and calcium deficiencies) of a much older person. For example, in the Downtown East Side of Vancouver, hard-to-house and homeless single persons aged 45+ are considered elderly.

3. KEY INFORMANT INTERVIEW FINDINGS

The 20 key informants interviewed in-depth, from Quebec, Ontario, Manitoba, British Columbia, and Yukon represent a mix of services: social housing, shelters, community-based and residential care at both provincial and regional levels, and addictions services. Their knowledge, wisdom, and opinions are presented here. (Key informant interview guides are in Appendix C and a list of key informants is in Appendix D.)

3.1 Elderly Homeless Persons

Informants in five jurisdictions of Canada made it clear that the number of homeless persons of all ages is increasing and shelter providers are hard pressed to meet the need. Their priority is to provide shelter to as many homeless people as possible, regardless of age.

In British Columbia (BC), shelter providers reported that the number of homeless people is on the rise; shelters have to turn people away. The homeless population is typically two-thirds to three-quarters male and there are more persons aged 50+ seeking shelter than ever before. In Winnipeg, of the 1500 persons who used the Mainstreet Project shelter in 2001-2002, 22 percent were aged 50+, a proportion that is growing. (The average age of shelter users was under 40 a few years ago; it is now 42.) In Montreal, shelter providers say that persons aged 50+ represent from 20 to 33 percent of clients.

Elderly shelter users (aged 50+) have been found to stay longer in shelters than younger people. For example, at Lookout Society in Vancouver, the average length of stay for persons under age 50 is nine days; for those aged 50+, it is 12 days.

For the most part, shelter services are offered to a range of ages. Providers stress that many of the problems confronted by older homeless persons, such as alcoholism, mental illness, poor physical health, and addictions, are no different from the problems of homeless people of all ages. Providing support, regardless of age, is the providers' priority.

3.2 Chronically Ill and Disabled Homeless Persons

It was consistently reported that homeless adults of all ages who are seeking shelter have more complex health problems than ever before, due to several factors: de-institutionalisation of people with mental illness; shortened hospital stays, so that people are discharged when they still need considerable care; and restricted residential care (nursing home) capacity. Many older and chronically homeless persons suffer from alcoholism and mental health problems. Some service providers also spoke of gambling as an increasingly prevalent problem.

Shelter providers see clients who have Hepatitis C, diabetes, emphysema, respiratory infections, tuberculosis, HIV/AIDS, mobility impairment, abscessed cuts, foot problems (mostly related to insufficient bathing), stroke, heart conditions, pneumonia, and dementia of different sorts. Younger shelter users are more likely to have HIV/AIDS and Hepatitis C, whereas older shelter users are more likely to be suffering from dementia, stroke, heart conditions, and incontinence.

Most shelters cannot accommodate clients who are unable to do their own activities of daily living (such as personal care) because shelters have neither the number of staff nor the expertise required to provide hands-on care. (Some BC shelters did get home care services delivered on-site, but these services had been cut at the time of research. Similarly, in Montreal, personal care was available in the transitional housing portion of one of the larger shelters until a few months before data collection, when they were cut.)

Physical accessibility of shelters is an increasingly apparent problem. Some shelters, especially those built many years ago, are not designed for persons with mobility impairments. Convalescent care for persons leaving hospitals is also an issue. In BC, more and more homeless people are being discharged directly from hospitals to shelters, because they are considered too sick or too weak to return to their previous homes (e.g., single room occupancy hotels, friends' couches, or the street). The number of people referred from hospital directly to a Triage, a shelter with services in Vancouver, doubled between 1994 and 2000, for example. At the same time, many people who were discharged directly from hospitals to hotels could not manage, were evicted, and eventually found their way to shelters.

Some shelters provide a few beds for persons needing bed rest; however, medical staff is not always available. In Winnipeg, home care is apparently difficult to arrange for shelter users. In Montreal, the local health and social services centres (CLSCs) do provide some home care in shelters. Some shelters, such as one in northern BC, have sought and received special funding for designated "long-term stay" beds. ("Long-term stay" in this instance refers to several weeks.)

Service providers spoke of "dumping" [1] by hospitals. Patients who are discharged, put into an ambulance or taxi, and sent to a shelter can become "a ping pong ball" if the shelter refuses them and sends them back to hospital. Some shelters have had to develop criteria for refusing referrals from hospitals.

Persons with chronic illness are acknowledged to have particular difficulties. These include the lack of preventative care or early medical attention. For

[1] In Montreal, "dumping" is not only practised by hospitals, but also by psychiatric hospitals, prisons and a psychiatric prison.

example, homeless persons with diabetes may neglect problems such as ulcers until they become much more serious and develop into gangrene, perhaps requiring amputation.

It is speculated that with the ageing of the current homeless population, drug addiction will become an issue for the next cohort, although their life expectancy will likely be shorter. Along with hard drug addiction, increases in Hepatitis C, HIV/AIDS, and brain damage due to "sniffing" are expected.

3.2 Access to Residential Long-Term Care for the General Population

There are some general trends regarding access to residential care (sometimes referred to as nursing homes) in Canada. One clear trend is that there are not enough beds to meet current need: resources have not kept pace with the growth of the elderly and/or chronically ill populations.

A related trend is that provincial funding/subsidy of residential care has been so restricted in some jurisdictions in recent years, only those people who have very high, complex care needs can be placed in publicly funded residential facilities, and therefore assessment procedures and criteria have changed. For example, the practice of listing clients who are awaiting placement in residential care has been revamped in BC, so that only those people who are "at intolerable risk" and need 24-hour nursing care are listed.

The policy in provinces where access to residential care has been severely restricted is that lower levels of care can and will be delivered by community-based agencies delivering home care to clients in their homes. Unfortunately, it is reported by health service providers in various jurisdictions that community-based care cannot meet the increasing volume and acuity of need in the community, due to limited financial and human resources.

Another clear trend across Canada is an attempt to fill the gap in personal care services by introducing supportive living options, including supportive housing and assisted living. Both options typically take the form of congregate housing with support services (but not 24-hour nursing care). This trend to provide services in a "housing" rather than an "institutional" setting, while generally accepted as a positive paradigm shift, has not been able to keep up with demand. There are not enough subsidized supportive living spaces in the provinces studied. (For example, in Ottawa there is a wait of up to three years for subsidized assisted living.)

The larger context for elderly and/or chronically ill homeless people needing residential care, therefore, is one in which there is already a higher demand than supply, for all segments of the population.

3.3 Access to Residential Care for Homeless Persons

There are several more barriers to residential placement for homeless persons in particular. These include the assessment process, need for advocates, and lack of co-ordination among services.

Assessment Process

In order to access a residential care bed, a person has to be assessed. Assessment is usually done by a case manager in the health care system in response to a request from a worker in the shelter or street outreach team. Assessment forms typically address such factors as ability to do activities of daily living, cognitive functioning, medications, mobility, support system, incontinence, and the potential for injury to self or others. (Categories of information on assessment forms do not differ dramatically by province.) A high aggregate risk score means that the person is eligible for residential placement. The process of assessment requires time and continuity. Assessments are not commonly undertaken in shelters because, for example, shelter users may have difficulty

keeping appointments and staying in the same place for a predictable period of time. Strategies to overcome these difficulties are to give a bed in a transitional housing project to a homeless client for long enough to be assessed, or make efforts to find a room or some other form of housing that permits assessment. For many shelter users, being a patient in the hospital is often the fastest way to get a residential care bed.

Need for Advocates

There is an extra set of barriers confronting elderly and chronically ill homeless people: lack of a personal advocate. Since homeless people often lack family and social support networks, most do not have a personal advocate to help them learn about and access the health care system. Even where there are advocates (e.g., liaison workers in shelters), there is sometimes discontinuity in service. This discontinuity, an outcome of front line workers' burnout and frequent staff turnover, can mean that building relationships, considered basic and necessary to working effectively with homeless people, may not be done.

Ease of Co-ordination Among Services

Service providers also spoke of the difficulties of co-ordinating numerous agencies. In small towns, such as those in the north, "all the workers know each other, so they just call each other". Similarly, in Victoria BC, a relatively small city, there is a weekly clinical and case conference attended by practitioners from diverse agencies who work collaboratively to become familiar with and address homeless and hard-to-house clients' characteristics and needs. For service providers in large cities, such as Toronto and Vancouver, however, it seems to be more onerous to make connections among specialties (shelter, permanent social housing, residential long-term care, community-based care and hospitals).

Co-ordination of services in Quebec appears to be slightly more entrenched at the front-line level than in other provinces. In Quebec, there is a network of multi-service, multi-disciplinary centres -- Community Health and Social Services

Centres, or CLSCs, serving specific geographic areas all over the province. CLSC workers conduct assessments of homeless clients and make recommendations regarding services or placement at weekly meetings of multi-disciplinary teams. For example, in downtown Montreal, the CLSC Les Faubourgs has a team that deals exclusively with homelessness. Nurses, social workers, and doctors from this team pay regular visits to the shelters (once or twice a week). This link between shelters and CLSCs not only facilitates the delivery of support to homeless persons, it is also a means by which they can be integrated into the medical and social systems.

3.4 Supports Needed to Accommodate Homeless Clients

When asked what supports health care and shelter providers need to be able to meet the needs of elderly and/or chronically ill homeless clients, informants stated that the first thing they need is access to subsidized, supervised housing. This housing should be accessible for people with mobility impairments and should include a meal program. They claim that if the homeless were housed in a multi-unit setting such as this, home nursing and support services could be delivered efficiently and placement in residential care could be avoided or postponed for many. The second thing they need is "simply enough residential long-term care beds!" for those homeless people who need 24-hour nursing care. Another need uncovered during research is the need for inter-departmental collaboration at the program and policy levels in governments, rather than at the service delivery level only.

Specific resources needed by front line workers in both the community-based health care and shelter sectors are:

- support from providers in a variety of sectors (i.e., a team approach),
- more trained outreach workers,
- continuity in case management,
- smaller case loads for case managers,

- dedicated advocates working on behalf of homeless people - e.g., to help with the paperwork for both housing and residential care applications,
- psychogeriatric consultants, especially social workers, to be "the link" between the homeless and residential care,
- flexibility in residential placement criteria, and
- an appeals process that allows front line workers to explain the particular needs of their homeless clients to providers of residential care.

Resources needed by residential care facilities to help them accommodate formerly homeless people who need 24-hour nursing care, are:

- access to a geriatric assessment and treatment unit, so that potential residents can be fully assessed before placement,
- assurance that they will received monthly payments for rent and any services included in the rental package (this will usually require that the client has been declared financially incompetent),
- commitment from the primary case worker to provide continuity in support, that is, on-going liaison between facility staff and community-based case managers,
- facility staff who are knowledgeable about homelessness and who are creative problem solvers,
- the flexibility to provide support/care at the margin of need only, allowing residents the level of autonomy they can manage (which may vary over time), and
- quiet, peaceful, and safe environments.

3.5 Mainstream Residential Care Facilities

According to some informants, mainstream residential care facilities are generally not considered suitable environments for homeless people. "Being homeless is being part of a culture. Mainstream culture is different." This difference is more pronounced for homeless people who are "street entrenched". Sometimes,

formerly homeless people who have been placed in a care environment are ostracised for their behaviour. This worsens their psychological health.

According to others, some shelter users have moved to mainstream facilities with success. (Typically, they would have been placed in an ad hoc manner, however, not as part of a special program.) In Toronto, for example, some very frail women have moved into long-term care although they may still visit the shelter for social contact. Similarly, in Montreal and Winnipeg, some previously homeless persons have moved into mainstream residences, while others found them too restrictive or felt lonely and left.

The integration approach, whereby homeless people are integrated into mainstream facilities, might work especially well for homeless people who have not been homeless for long. For example, one elderly homeless woman in Vancouver was homeless for a short time after being evicted from her home due to non-payment of rent. This, it was discovered, was due to a dementia. She was put on an emergency list for residential care and placed.

Long-term care providers expressed the view that for residential facilities to be able to accommodate formerly homeless people, the facility staff need to be informed about the culture of homelessness and about the reasons for the client's homelessness. At the same time, shelter workers seeking placement for their clients should only do so if they are confident that their clients do not have predatory or violent behaviour, disturbing rituals related to substance abuse, or any other behaviours that would have a negative impact on the residents who are already in place.

One of the main behaviours that disqualifies elderly and/or chronically seriously ill homeless people from residential care is excessive use of alcohol. For example, one care worker in BC stated that "very, very few residential care facilities in the area accept someone who uses alcohol excessively". Some do not allow alcohol

consumption even in moderation. One shelter worker spoke of a client who has been in the habit of "drinking his beer every day" who found that this was not allowed in a residential facility. One outcome of such restrictions is found in Vancouver, where there are "people who cannot live independently in the community, are eligible for residential care, are refused, and as a result are living in Downtown Eastside hotels because this is the only area that will tolerate their behaviours". Some residences (such as the Résidence du Vieux Port in Montreal) do not allow alcohol consumption on the premises, but do tolerate alcoholism and some disorderly behaviour in the residence.

Another behaviour not well understood by mainstream care providers is the need of some homeless people for space and the outdoors. For instance, one homeless person admitted to hospital with pneumonia, who frequently went outside, was discharged because it was thought he was "wasting a bed".

Other difficult behaviours making integration of the homeless population difficult are heavy smoking, poor personal hygiene, poor housekeeping skills and anti-social behaviour, such as using foul language. Some of these difficulties may be related to mental health problems that appear to be fairly prevalent in this group. These behaviours are not acceptable in mainstream residential facilities, which are predominantly occupied by physically frail, elderly females with cognitive impairment. Not only is there a "culture clash"; there is also fear among nursing home administrators and caregivers that their vulnerable residents might be at risk if "rough" residents (to quote an informant) were admitted.

This cultural barrier is not easy to overcome. Some informants suggested that mainstream residential care providers of all levels – administrators, nurse managers, and hands-on providers -- need more education about the background, habits, illnesses, and motivations of homeless people so that they can manage them better. Regular and continued interface between community health workers (such as outreach teams) and staff of residential care facilities

would increase the probability of successful integration of homeless people in mainstream facilities.

Informants generally agreed on two things.

- Both integration and segregation approaches to providing long-term care to homeless people should be considered.
- The move to a residence and integration into a new social group is challenging for anyone, regardless of their characteristics.

3.6 Long-Term Care Strategies for Elderly or Chronically Ill Homeless Persons

Interviews with service providers are not conclusive in terms of "the ideal" long-term solution for older or chronically ill homeless persons. A range of options and a range of providers are needed, starting with more supportive housing. Lack of sufficient subsidised and supportive housing was stressed by almost all informants. In both Montreal and Vancouver, shelter providers spoke of the loss of affordable housing in the downtown area. Where supportive housing options have been developed and provided, in Montreal, Ottawa, and Toronto, for instance, demand already far outstrips supply.

In some cases, de facto residential care is being provided in housing environments. For example, some residents of Winnipeg's Mainstreet transitional housing (34 beds) have been living there for over 10 years. Boarding houses are considered a viable option, since services include meals and other supports. (One shelter worker, however, spoke of reluctance to send clients to certain boarding houses that solicited residents in the shelter, because some of these homes had been found to be exploitative of fragile and vulnerable persons. Quality assurance checks of these boarding houses are not always done due to lack of funding.)

A continuum or graduated strategy to meeting the needs of clients is preferred by informants. According to one shelter provider, the ideal solution would be a range of options providing different levels of support and care, within close proximity to each other, so that needs could be met in a continuous and co-ordinated manner. This continuum can stretch from supportive housing at one end to palliative care at the other. Informants gave four examples of palliative care being provided to homeless persons: the Résidence du Vieux Port in Montreal, Hazelton Residence and Veterans' Manor in Vancouver, and Hospice for the Homeless in Ottawa. (See Case Studies, Appendix E.)

3.7 Ideal Residential Care Facilities for Elderly, Chronically Homeless Persons

Key informants were asked what an ideal residential facility for this group would be. While some of the responses were very specific, as illustrated below, a number of shelter workers emphasised one philosophy above all: "It has less to do with the building and more to do with validation of the human being …and the range of care that is offered."

Shelter workers stressed the importance of giving persons their dignity and supporting them instead of imposing expectations. "I am amazed at what some of these persons have experienced throughout their lives and the difficulties they may have encountered from a young age. Yet they maintain their humour, their humanity, and their dignity. This is what keeps me going in my work."

Following are some of the suggested characteristics of the ideal residential care environment specially designed for elderly or chronically ill homeless persons.

Location

There are mixed opinions about the preferred location of a care facility for homeless people. Generally, the preference is the downtown area – close to

services and familiar to residents, but “not in the core, drug using area”. There was a case in Winnipeg where homeless persons were moved from a facility when it closed and were dispersed, some far from the core of the city. This group all died within a short period. There is a similar story from Whitehorse, of a small community of homeless men, squatters, who were dispersed to care environments where they did not thrive.

Alternatively, some informants expressed concern about the vulnerability of persons to downtown predators and suggested that a location in the outskirts of the city or in the country is most appropriate.

Housing Form and Scale

The form of housing/accommodation should be fully accessible, while non-institutional, possibly made up of “mini-communities” of private and semi-private rooms for residents. Two service providers said that a lockable room with two-piece bath and small kitchenette is an appropriate private dwelling space for homeless people who typically do not have housekeeping skills. There should also be communal rooms for dining and social events, case rooms where home nurses can do their work, and tub/bath rooms (with intercom to an in-house service provider) where home support workers can help residents with bathing and which will be cleaned by staff. The scale should be small (30-50 units per project at the most). Men and women should not be segregated into separate buildings.

Service providers’ advice is to “use what’s there”, including hotel/motel stock, or under-utilized personal care homes; and where possible, cluster people with like needs (e.g., brain injured adults, or those who have problems with alcohol) so that appropriately trained staff can work with them in an efficient way.

Services

Services should be based on a holistic approach to support/care. Basic services would include financial administration and the delivery of health services, support services such as meals and escorts to doctors' appointments, and social/recreational activities. Services should be provided in a flexible manner and residents who are able should participate in running the home.

Staff

There needs to be 24x7 on-site supervision; however, depending on the health status of residents, there may not be the need for 24x7 on-site support and care staff. In many cases, 12-hour staffing of on-site services would meet the need. Key staff members would be a lifeskills coach (who "does with" rather than "does for" residents), a licensed practical nurse, a recreation aide, a social worker, and other workers to do residents' personal care and in-unit cleaning.

Philosophy

The philosophy underlying delivery of housing, support and care should be client-centred, based on respect for their humanity and adulthood. Theoretical underpinnings should be "healthy ageing", "harm reduction", and client-centred care. The common tenets of these three philosophies are: respect for individuals, their histories and differences; individualised approaches to their support and care; lack of judgement of their behaviour; and an emphasis on abilities rather than on disabilities.

4. CASE STUDIES: A SUMMARY OF FINDINGS

Thirteen case studies were carried out in five jurisdictions: Quebec, Ontario, Manitoba, British Columbia, and Yukon. Descriptions of the 13 case studies are in Appendix E.

This chapter summarises research findings under the following categories: location, housing form and scale, client characteristics, services, staff, development history, and philosophy. Each reference to a specific case study in this chapter is followed by the case study number in brackets, for example (#3).

Location

Many of the projects are in the central core of cities, facilitating their access to centralised services, such as day centres, government-subsidized cafeterias, and medical facilities. It is not clear, however, whether locating residential care for this population in the downtown core is ideal. There is concern that the planned relocation of the Résidence du Vieux Port (#6) to downtown Montreal, for example, may be detrimental to the elderly clients. Birchmount Residence in Toronto (#8) and Fairway Woods in Victoria (#12) are both examples of a decision to move clients to a suburban location.

Housing Form and Scale

Projects included in this study range in type from a purpose-built four-storey supportive housing project, to a palliative care facility attached to a shelter that has been operating for almost 100 years, to a hotel that has responded to local need. Half of the sample was converted or adapted, rather than purpose-built. The number of residents ranges from 14 to 60 (although there will be 72 in the future Résidence du Vieux Port, #6).

In cases where the facility is attached to a shelter or day centre used by homeless persons of all ages, steps have been taken to protect or separate the

elderly persons from potential predators. There are several ways to provide this security: the entrance to a residence is separated from the entrance to a day centre in the same building; all entrances are monitored by camera; the entrance to a facility for older clients is an elevator facing the reception area, to allow surveillance of those coming and going; and interior courtyards with gardens provide protected, outdoor space for residents.

Client Characteristics

Clients/residents have numerous characteristics in common: most are aged 50+ and chronically homeless; most are male; they tend to be addicted to alcohol or other substances; often lack social and life skills; and they have few or no family or friendship support networks. In addition, they have numerous health problems, including mental illness, cognitive impairment, arthritis, cardiovascular disease, diabetes, AIDS, malnutrition, fatigue, and a host of other physical ailments that result from "living rough". They require assistance with life skills, help in budgeting and, in many instances, help to find permanent, affordable housing. In these ways, they are no different from homeless people of all ages. They are different from other homeless persons, however, in that they may be physically weaker, their senses may be impaired, their health problems may be more complex, and they may be more entrenched in a homeless lifestyle than younger homeless persons.

Services

In all cases, there is a reliance on a network of services, including regional health authorities' home support, home nursing and multi-disciplinary outreach services. The array and intensity of services offered in the 13 projects and the number of sources and referrals of clients/residents reflect inter-sectoral, inter-agency collaboration. Services typically include financial management, supervision of medications, at least one meal per day, housekeeping, and personal care.

Staff

Staff are typically multi-skilled and multi-experienced -- they are from the fields of nursing, psychiatry, addictions, housing, social work, and the clergy.

Development History

Many, but not all, of the projects were developed by established shelter providers who expanded their facilities and services to respond to the increasing volume and acuity of need among elderly and chronically ill homeless people. Examples of this approach are the Infirmary (#2) and Birchmount Residence in Toronto (#8), the Maison Claire Ménard in Montreal (#7), the Résidence du Vieux Port in Montreal (#6), the Hazelton Residence in Vancouver (#4) and Fairway Woods in Victoria (#12). Governments at all levels have worked with professionals, community groups, non-profit associations (such as retirees), and volunteers to create and sustain these examples of housing and care for elderly and chronically ill homeless persons.

Philosophy

The pervading philosophy of the projects studied is client-centred decision-making and respect for human dignity. Harm reduction (that is, allowing persons who are addicted to substances to continue using them in moderation) is the model for some cases (Birchmount Residence, #8, and Seaton House Infirmary, #2), whereas in others (Résidence du Vieux Port, #6), alcohol consumption is not allowed on the premises, but behaviours associated with alcohol misuse are tolerated. Tolerance -- of alcohol misuse and its effects, of certain behaviours, and of poor personal hygiene -- is clearly a distinctive feature of the approach to support and care. Conversely, intolerance of these characteristics is one of the major obstacles to the integration of many homeless persons into mainstream facilities.

Case Studies of Housing Options for Elderly and Chronically Ill Homeless People

#	Name	Location	Services/Clients
Health			
1	Hospice for the Homeless	Ottawa ON	14-bed hospice, part of The Mission (also offering shelter and supportive housing). Provides 24x7 palliative care to homeless men and women.
2	Seaton House Infirmary	Toronto ON	35-bed facility with 24x7 staff for homeless shelter users discharged from hospital who are too ill to return to the streets. Services include palliative care.
3	Integration of Health and Shelter	Toronto ON	A multi-faceted approach to integration of health and shelter services by Seaton House and St. Michael's Hospital, which includes a Transition Centre within Emergency Department, a Homeless Person's Protocol, and a Fusion of Care Model.
4	Hazelton Residence	Vancouver BC	39 "Special Needs Residential" rooms for seriously ill homeless persons (e.g., AIDS, mental illness). On-site support, medical visits. Palliative care as needed.
Mobility Impairments			
5	Transitional Housing (proposed project)	Winnipeg MB	Self-contained apartments, therapy, counselling, and 24x7 attendant care for homeless/at risk Aboriginal persons with severe mobility impairments.
Residential			
6	Résidence du Vieux Port	Montreal QC	40 rooms for homeless men over 50 opened in Old Montreal in 1987. Plans are currently underway to move it closer to the Maison du Père (shelter) located in downtown Montreal and increase the number of rooms to 72.
7	Maison Claire Ménard	Montreal QC	31 self-contained units, in same complex as day centre in Old Montreal. For homeless men aged 50+.
8	Birchmount Residence	Scarborough ON	18 rooms with 60 beds in residential facility with on-site support and care providers, for vulnerable homeless men aged 50+. Harm reduction model.
9	Legion Wing	Prince George BC	22 housekeeping rooms, daily meal and support programming for homeless or at-risk men and women incapable of self-care due to complex health problems.
10	Veterans' Memorial Manor	Vancouver BC	134 self-contained apartments, plus on-site security 24x7, support services from community agencies, subsidized meals on-site, for male veterans aged 55+.
11	Integrated Program (former)	Victoria BC	3 beds in mainstream residential care facility dedicated to at-risk seniors who are clients of community-based addictions program. Recently cancelled.
12	Fairway Woods (just opened)	Victoria BC	32 self-contained apartments in new purpose built project located in suburbs. For homeless and hard-to-house tenants with multiple health problems.
13	Pioneer Inn	Whitehorse YK	18 rooms in hotel in Whitehorse, providing support services and four meals/week.

5. SUMMARY AND CONCLUSIONS

Many of the findings from the literature review were confirmed by this exploratory study.

- The issue of elderly homelessness has not been studied sufficiently. In the US, Australia, and the UK, elderly persons are generally a small proportion of the homeless population; this may be one of the reasons why research into this group is not extensive. The reasons for their relatively small number include the high mortality rate of homeless persons, their avoidance of shelters and services (i.e. “invisible” homelessness), and the social supports offered to persons over 65, reducing the risk of homelessness.
- Canadian counts of homeless persons that were reviewed also reveal generally small proportions of elderly homeless persons (from 9 up to 35 percent, depending on categories of age and location).
- Canadian studies show that older homeless persons are likely to use shelters for longer periods than younger homeless persons (although some are homeless only once, often due to eviction from their homes).
- Older homeless people are also more likely than younger homeless people to be sent directly to shelters from hospitals.
- Studies have found that elderly persons have more trouble staying in permanent housing than homeless persons of other ages. It could be partly due to inadequate or badly conceived support in the re-housing strategy.
- There is considerable vulnerability among the homeless elderly and a need for safety and protection, especially from other homeless persons.

- While the health problems of homeless persons are similar to those of the general population, they occur at a much higher rate.
- Homeless persons are also more likely to die of preventable causes.
- Providing health care to homeless persons is a significant problem due to complications that emerge from shelter life and access to health care.

Interviews with Key Informants

Interviews with key informants from both the long-term care and homelessness sectors reveal similarities in their situations: they have insufficient resources to meet the need – whether the need is for shelters, transitional housing or residential care. More specifically, there appear to be relatively few housing options responding to the needs of the older, homeless population.

Within the shelter system, the need for services for homeless persons, no matter what their age, is overwhelming. Similarly, within the residential long-term care system, the needs of chronically homeless persons, especially those with mental health or behavioural problems, are hard to meet, especially given the difficulty of meeting the needs of the regular clientele.

Interviews also reveal that:

- The issue of elderly, homeless women appears to be relatively unknown or undocumented. It is not clear whether they more easily integrated into mainstream residential facilities or are accommodated in the existing shelter system. No project designed specifically for this population was identified by key informants.
- While many shelters are barrier-free, some remain inaccessible. Only one project addressing the specific needs of homeless persons with mobility problems was identified (and documented in this study).

- Persons needing personal care typically cannot be accommodated in shelters – most shelters do not have the human or financial resources to provide this assistance.
- Co-ordination and integration of health services and shelters is an area of considerable concern, especially discharge planning for homeless patients leaving hospitals. Integration of these sectors is still in its infancy in many cities.

Case Studies

Although the 13 case studies reported here do not necessarily represent the full range of Canadian initiatives for elderly or chronically ill shelter users, they do provide substantive and valuable information and lessons that warrant attention.

The projects dealing with health issues confirm the findings from the key informant interviews: integration of health and shelter services is still rare in Canada. The work undertaken by Seaton House and St. Michael's Hospital in Toronto appears to be exceptional. Similarly, palliative care for homeless persons is delivered primarily on an ad hoc basis and with limited resources, except for a few notable examples such as the Mission Home Hospice in Ottawa and the Infirmary at Seaton House in Toronto.

With an ageing population, an intensifying homelessness problem, and increasingly complex and serious health problems within this population, it is clear that a more systematic approach to palliative care will be needed in the future.

Few examples of an integrated approach between shelters and mainstream long-term care facilities were found. One example (from Victoria BC) that is documented has been cancelled, while Birchmount Residence in Toronto has a number of units reserved for its residents in a local seniors housing project in exchange for activities and support. Most projects described in this study were

developed specifically for older or chronically ill homeless persons by larger homelessness facilities. The advantage of this approach is that the facilities are adapted to the target population (e.g., tolerant of certain characteristics such as alcoholism, addictions, mental health or hygiene problems) and include integrated supports and services, such as lifeskills assistance. While many key informants from the homelessness sector did speak of homeless persons' being placed in mainstream residential care, such placements are undertaken on an ad hoc basis within the context of an already overburdened system.

The development of housing and services dedicated to elderly homeless persons by larger shelter services raises a number of issues. One is protection of the vulnerable elderly persons from younger, potentially predatory clients. Measures to protect elderly residents include monitoring entrances (with cameras or reception surveillance) and developing housing for elderly clients in buildings and locations that are separate and distinct from large shelters. This strategy, in turn, raises questions about the ideal setting for housing options for elderly and chronically ill homeless persons. Case studies included projects in both city cores, close to support and services and in outlying areas, away from irritants and dangerous situations.

Support from governments at all levels, as well as inter-sectoral and inter-disciplinary collaboration, appear to be keys to success. Another important ingredient seems to be a community-development approach: that is, needs are identified and change is made "from the ground up", with community members and front line providers as agents of change.

Despite the development and delivery of the solutions reported in this document, the needs of elderly and chronically ill homeless people in Canada are still largely unmet. Most of the facilities documented in this study have waiting lists. Service providers stated that even if the number of places they can offer were doubled or tripled, the need would still be unmet.

6. SUGGESTIONS FOR FURTHER RESEARCH

There is a thirst for information exchange and communication on experiences related to providing accommodation, support and care to elderly and chronically ill shelter users. While successful solutions for this client group have been designed, developed and delivered in various regions of Canada, the providers generally do not have the time or budget to record and share their challenges, successes and triumphs with others doing similar work in other parts of this large country. Thus, there is a need to provide an affordable forum, or method, for providers to share their experiences, ideas, and opinions.

There is also a need for more research on several topics related to this exploratory study.

- The experience of Birchmount (#8) in overcoming the initial NIMBY (Not In My Back Yard) reaction of the community should be further documented, so that successful strategies can be shared. This knowledge is not only valuable to providers of homelessness services, but could be useful to any agency or department wishing to develop supportive housing and services in residential communities.

- Projects ranging widely in scale were documented in this study. Key informants generally agreed that the ideal size of a project is 30-50, or better still, about 25 persons; yet in reality, facilities seem to need the economies of scale that result from having more clients/residents under one roof. A study of the financial viability of several projects, ranging in scale, is in order.

- The wisdom of integrating a residential care facility with a large shelter serving homeless people of all ages is in question, because the elderly, frail population is vulnerable to younger predators. A study focussed on

the various ways that have been used to separate and protect more vulnerable homeless persons is warranted.

- This study identified no initiatives addressing the needs of elderly homeless women, although women represent a notable proportion of the homeless population. More research is needed on this topic.

- A community development approach -- whereby community members, service providers, clients and other immediate stakeholders define the problem, envision and participate in developing the solution -- seems to be common to a number of the projects studied. The impacts of this approach, versus a planned, policy-driven approach, could generate many valuable lessons.

- Several case study contacts stressed the importance of providing formerly homeless residents/clients with recreational and leisure opportunities, to create social interaction and eventual social reintegration. The short term impacts and longer term outcomes of this kind of intervention could reveal an array of social (rather than medical or residential) solutions to meeting the needs of this population.

- This study reports some of the difficulties of assessing and placing homeless persons in mainstream residential care; however, it does not go further to examine how formerly homeless people do adjust to residential care and how facilities adjust to them. This knowledge would be valuable to residential care providers, discharge planners in hospitals, and community-based health service providers.

APPENDIX A: LITERATURE REVIEW

TABLE OF CONTENTS

1. INTRODUCTION 34

2. PREVALENCE OF ELDERLY HOMELESS PERSONS 35

Canadian Data 35
American Data 37
Data from the United Kingdom 38
Data from Australia 39

3. PATTERNS AND SPECIFIC FEATURES OF ELDERLY HOMELESSNESS 43

Chronicity and persistence of homelessness among older persons 43
Victimisation and vulnerability among elderly homeless persons 45
Shelterisation 46

4. HEALTH 47

Physical health and homelessness – all age groups 47
Mental health and homelessness – all age groups 50
Physical health and homelessness – the elderly 51
Access to health care – all age groups 52

5. LONG-TERM SOLUTIONS AND RE-SETTLEMENT 53

Long-term solutions and re-settlement of older homeless persons 55
Respite services 56

1. INTRODUCTION

This literature review examines studies and reports undertaken on two themes that converge: the elderly homeless and homeless persons with chronic illness. As already discussed, the poor health of homeless adults, especially the chronically homeless, ages them beyond their years. While literature on health issues for homeless persons is abundant, perhaps reflecting the public cost of physical and psychological illness, there is still acknowledgement among researchers that the issue of elderly homelessness has not been studied sufficiently. As the next section of this review reveals, elderly persons are generally a small proportion of the homeless population; this may be one of the reasons why research into this group is not extensive. The literature does not clarify why the proportions are lower. The explanations that are advanced range from a process of "natural selection", tied to the high mortality rates of homeless persons (e.g. O'Connell et al. 1990), to the avoidance of shelters and services making elderly homeless persons "invisible" (e.g. Kutza and Keigher 1991), to the greater number of social supports offered to persons over 65, thereby reducing their risk of homelessness (e.g. Cohen 1999).

This literature review focuses primarily on the issue of elderly homeless persons, beginning with a review of studies undertaken on prevalence and profiles, a discussion of the causes of homelessness among the elderly, and issues that arise in finding solutions. This discussion of the elderly homeless is followed by an overview of health issues for homeless persons, with particular attention to those that affect the elderly and the issues that arise in treatment. A final section presents a very generalized and random overview of some of the approaches to deal with elderly and ill homeless persons, based on what has been described in the literature reviewed, rather than on a more comprehensive search of projects and programs.

2. PREVALENCE OF ELDERLY HOMELESS PERSONS

Canadian Data

The lack of a consistent definition of "elderly" or "seniors" moves from the realm of theory and into practice when data on numbers of homeless persons are analysed and compared. This section reviews a number of studies undertaken in Canadian cities and elsewhere on the prevalence and profile of elderly homelessness or homeless seniors. The overview of the studies illustrates some of the difficulties in defining homelessness (e.g. sleeping rough, use of shelters, use of services) and the complexity of counting homeless persons. Some counts are based on "point in time" or one-day counts (e.g. Vancouver) [2], while others are prevalence studies (e.g. Montreal, a one-year period), and others are for a much longer period of time, such as nine-year data collection of Toronto hostel users.

Toronto

One of the richest sources of information about homeless persons is Toronto hostel data. Analysis of the data collected over a nine-year period (1988-1996) reveals that 13 percent of users were 45 to 64 years old and 2 percent were over 65, leading the authors to conclude "persons over 45 are much less common in the homeless population than they are in the general population of Toronto." (Springer et al. 1998). The researchers analysed hostel data more closely for chronicity, however, and found that those over 50 years (10 percent of the users) stayed in hostels two times as long as those under 50. The Toronto data also reveal that:

- 24 percent of hostel users over 50 were women.
- The cause listed for use of the hostel is more frequently listed as "transient" or "unknown" for this age group, ranging from 37.5 percent for those 50-54 to 42.3 percent those over 65. The proportion for all hostel users is 29 percent.

[2] It has been proposed that the population that is homeless over a year is 3 to 5 times that counted on any one night (Crane 2001).

- Hostel users over 50 are over represented among those who come into the system from hospitals – 5 to 7 percent of this age group compared to 3 percent of all hostel users.
- Furthermore, those coming from hospitals and other treatment programs, as well as those coming from the corrections system, are the two most "chronic" types of users. "Hospital discharges have a 28% probability of 1 year or more in the hostel system, and those from corrections have a 30% chance. Their exit into stable housing, both private and subsidised, is lower than expected. The expected proportion is 15 percent while that of users 60-64 years old was 9 percent and 11 percent for those 50-59 and over 65.
- Analysis of hostel data over the nine year period indicates an increase in the proportion of those under 18 and a decrease of those over 45; the latter dropping from 18 percent to 14 percent.

Montreal and Quebec City

A study undertaken by Santé Québec of shelter and day resources use in Montreal and Quebec City over a one-year period found that those aged 45 and over represented 35 percent of the population studied (Fournier et al. 1998). Older persons, when compared to other users of services and shelters, were found to have been married, had children, and not have worked in the last year.

Vancouver

A one-day count undertaken in January 2002 of the Greater Vancouver homeless population revealed that 5 percent were over 55 years and 15 percent were between 45 and 54 years (Eberle Planning and Research et al. 2002). Using 55 and over as the definition of senior, the researchers found that males predominated and most were "younger" seniors (between 55 and 64). The greatest proportion stated that eviction was the cause of their homelessness (25 percent) and most (59 percent) had been homeless for less than a month. They were found to have relatively poor health; 78 percent had at least one health

condition compared to 66 percent of all homeless individuals surveyed.

Calgary

Data on four month utilisation of inner city homeless agencies and shelters in Calgary (Holley and Arboeda-Flórez 1997) found that 13 percent of users were between 45 and 54, 6 percent were over 55, and 14 percent were women, a lower proportion than those in the younger age groups. Further analysis of the data reveals that older shelter users consume a greater proportion of resources compared to younger age groups. Thus, while those aged 55 and over represented 6 percent of the study population, they were found to consume 10 percent of resources.

Edmonton

A one-day count in Edmonton (Edmonton Task Force on Homelessness 1999) found 836 homeless persons (absolute homeless and persons living in shelters and other emergency accommodation). Those over 55 represented 9 percent and almost all were living in shelters.

Census Data

The 2001 Census data provides information on collective dwellings, including shelters. While probably underestimating the number of homeless persons, 14,150 persons were found to be staying in shelters across Canada. Persons aged 65 and over were 10 percent of the total and over half were women (54 percent), whereas women represented 38 percent of all shelter users (Statistics Canada 2002).

American Data

A review of American homelessness research undertaken until 1997-8 found that while the proportion of older homeless persons had declined, the absolute number had increased and this trend would likely continue, given the ageing of the baby boom generation (Rosenheck et al. 1999). A review of shelter users in

eight cities found that up to 27 percent were aged 60 and over and that this group "may constitute an even higher proportion of the homeless population because older people may generally avoid using shelters" (Kutza and Keigher 1991). Other studies found very divergent proportions ranging from a high of 42 percent of men and 36 percent of women in Boston shelters to be aged 45 and over, to 24 percent of shelter users in the Bowery aged 65 and over, and a low of 6 percent of Chicago shelter users aged 55 and over (Kutza and Keigher 1991). In Boston, two surveys of elderly homeless persons found an increase of 25 percent between 1993 and 1997 in the "elderly" age group (Gibeau 2001).

Veterans appear to be a disproportionate population among older homeless persons (Buckner 2001; Hecht and Coyle 2001). Women are found to represent a larger proportion of service users, have higher levels of serious mental illness but lower levels of alcoholism, drug abuse and criminality when compared to homeless men and younger women (Rosenheck et al. 1999).

Data from the United Kingdom

Official statistics of the number of elderly homeless (aged 60 and over) in England indicate that the numbers have dropped from 6,020 households in 1994-5 to 3,740 in 1999-2000(Crane 2001). However, these data are for households and those who are statutory homeless [what does this mean?]. It is proposed that the actual number of elderly persons who are homeless could be twice the number reported in statistics, given that "rough sleepers", for example, are not included. Studies in London indicate that during 1999-2000, 19 percent of rough sleepers were aged 50 and older (Crane 2001).

A study of 225 homeless persons in Glasgow found that 34 percent of the sample were aged 55 and over with 90 percent male. A higher proportion of the younger groups had slept rough in the previous year, compared to those aged 55 and over. Long-term hostel users are more likely to be older: 15 percent of those aged 55 and over had been there for two to three years; 63 percent over 3 years.

In comparison, 25 percent of hostel users aged 35 to 54 and only 3 percent aged 25-34 had spent that long at a hostel (Kershaw et al. 2000).

Data from Australia

According to the Council for Homeless Persons (nd), an estimated 250,000 people 60 and over are homeless or at risk in Australia. These are people who rent, living in boarding houses or are homeless with annual incomes below $12,000. War veterans are 10 percent of this population. Data on Supported Accommodation Assistance Program (SAAP) users indicate dramatically lower numbers: 5 percent or 5,000 people

Causes of Elderly Homelessness

The literature reveals that the fundamental causes of homelessness for elderly persons are the same as for homeless persons of all ages: a combination of structural factors such as availability of employment and affordable housing, and personal factors such as strength of social networks, problems with drug or alcohol abuse, and psychiatric illness.

An Australian study situates youth and elderly homelessness in a context of "social disenfranchisement" which is a result of the economic and social restructuring that has included a shift of financial support from public to private spheres and a subsequent shortage of government-subsidised rental housing and decline in affordability (Hallebone 1997). In both the UK and the US, the loss of affordable housing (Bottomley et al. 2001; Rosenheck et al. 1999), access to such housing (Hecht and Coyle 2001; Hawes 1999), especially for minority elders in the US (Rosenheck et al. 1999), and inability to pay, including rent and mortgage arrears (Hawes 1999), are cited as causes of homelessness. Numerous studies have identified eviction as a precipitating cause of homelessness (Eberle Planning and Research et al. 2002; Hecht and Coyle 2001; Hawes 1999; Rosenheck et al. 1999; Crane 1999). Limited access to support services for minority elders was found to be a factor in homelessness in

the US (Rosenheck et al. 1999) and in London for homeless elders (Crane 2001), while a 1996 study in London found increases in homeless elderly persons to be a result of failures in the community care system (Hawes 1999).

When asked reasons for their current homelessness, both young and old shelter users in California had equally prevalent problems of job loss and lack of access to affordable housing. Older homeless persons, however, were significantly more likely to cite drug or alcohol abuse and/or injury or illness as causes, whereas younger shelter users were more likely to cite domestic violence and release from prison (Hecht and Coyle 2001). Differences were found between men and women: men were twice as likely to report that job loss was the precipitating factor while women were nearly three times more likely to report eviction. The authors conclude that, "the two types of structural causes of homelessness (jobs and affordable housing) may affect people differently according to gender" (Hecht and Coyle 2001).

Some studies link homelessness among the elderly with deinstitutionalisation. For example, Tully (1994) quotes a study of the US House of Representatives indicating that over 50 percent of homeless persons aged 50 and over suffer from chronic mental illness. A study in Detroit in 1988 found that discharge from an institutional context was the major immediate cause of homelessness among people 54 and over (Hawes 1999). Differences have been noted between men and women: women shelter users in California were on average five years older than men, and were significantly more likely than any other group to report a history of mental health problems (Hecht and Coyle 2001).

Intimately related to the need for affordable housing, job loss, and eviction is poverty. While elderly homeless persons may be "thought to have more consistent income from pensions or social security than younger homeless individuals, poor older women who have never worked, individuals with very limited benefits, and elders whose meagre incomes have been exploited by

others, are still too poor to support themselves in stable housing" (Rosenheck et al. 1999). Cohen (1999), noting the lower proportion of homeless persons aged 65 and over, attributes this to the availability of various financial entitlements and suggests that the "risk of becoming homeless is substantially greater for those persons between ages 50 and 65 than for those 65 and older."

The issue of relationships, relationship breakdown and the loss of social support appears to be another important factor in elderly homelessness and one that is raised in many studies.[3] Cohen (1999) found that older homeless persons are "not usually embedded in the diverse family network that characterizes their age peers in the general population." Hawes (1999) suggests that homelessness among the elderly can be seen as "an extreme outcome of family conflict". Family conflicts can be caused by retirement, unsatisfactory relationships that become untenable and failed second marriages or relationships. Violence, physical and psychological also can play a causal role, as can economic and financial conflicts. A study of older and younger shelter users in Bakersfield, California, found that while older users (over 55) were almost twice as likely to report having economic resources than younger users (e.g. Social security, disability income, and Veterans Administration income), the duration of the homelessness episode was longer. The researchers suggest that this might be due to fewer "social resources" on the part of older users, "that is, relationships with others that might help them to solve informally some of their housing problems, for example, by doubling up." (Hecht and Coyle 2001).

Crane (1999) in a study of elderly homeless persons in four cities in the UK found that the lack of affordable housing, poverty and unemployment had little influence on the shelter use of the participants in the study. The causes were found to be more complex and related to "personal inadequacies, stresses accumulated over years, and mental illness" (Crane 1999). This finding echoes a 1988 study in

[3] It should be noted that social and familial support are important causal factors in other groups of homeless persons, notably for youth.

Detroit that found that “lifelong difficulties in relating to other people” was a major factor in homelessness as well as lack of family support, criminal behaviour and drug dependency (Hawes 1999). Other studies note the high proportion of older homeless persons with “disruptive events in childhoods” or who had been brought up by relatives, foster parents or in orphanages (Cohen 1999). Crane’s research (1999) reveals that unemployment was not generally a factor in homelessness, and when it did play a role, it was set off by social and psychological states and events, such as giving up work and homes following bereavement or a relationship breakdown. Furthermore, it was found that while poverty was a reality once persons became homeless, few were poverty stricken before. Mental illness, distress and coping skills were found to lead to financial difficulties (Crane 1999). A 1993 study in the UK found that 16 percent of homeless persons aged 60 and over stated that their loss of a home followed the death of a spouse or close friend and 7 percent attributed their loss of home to relationship breakdown (Hawes 1999).

Crane (2001) distinguishes three major types of elderly homeless persons, in terms of the different pathways they have taken to homelessness. The first is persons who have been homeless since adolescence or early adulthood. In a study of 267 older homeless persons, 7 percent were found to have been homeless for 41 years or more (Crane 2001). The causes of homelessness for this group include broken and disturbed childhoods, as well as discharge from the armed forces or marital breakdown when young adults. A second group became homeless as middle-aged adults, having lived with parents all their lives and then finding themselves unable to cope on their own when parents died; or they had worked as unskilled workers and when unable to find work, found themselves homeless. The third group are persons who became homeless in old age. Homelessness for this group is triggered by widowhood, marital breakdown or mental illness (Crane 2001). Rosenheck et al. (1998) found similar patterns in their review of American research: older persons often became homeless for the first time at the death of a spouse, a child or a friend who had been the caretaker

or source of financial support. Although the pathways to homelessness may differ, all are found to have similar factors that come into play including “multiple or prolonged stresses, poor coping and social skills, a deficient support network, and mental illness and alcohol problems” (Crane 2001).

Some studies indicate that the process of becoming homeless for many older persons is rapid and abrupt. Crane’s study in four cities found that 60 percent experienced a rapid move from secure housing right into homelessness (Crane 1999). In Chicago, the majority of 157 elderly homeless persons had become homeless in the last year, citing eviction, family disputes and mental health problems as causes (Crane 1999). In Boston, surveys of elderly homeless persons between 1993 and 1997 found an overall increase of 25 percent in the number and an increase of 85 percent of newly homeless older adults (Gibeau 2001). Other research suggests more of a “slide” into homelessness. For example, a New York City study found that “older women had experienced an average of three life events or crises over a period of one to five years preceding their homelessness” (Cohen 1999).

3. PATTERNS AND SPECIFIC FEATURES OF ELDERLY HOMELESSNESS

Research into elderly homelessness identifies particular patterns and characteristics, including (as already discussed) the chronicity of elder homelessness, as well as their vulnerability, the process of “shelterisation”, and health problems that are particular to this group.

Chronicity and persistence of homelessness among older persons

Data from Canadian studies and elsewhere indicate that the problems of chronic homelessness are more acute with older persons (Kershaw et al. 2000; Springer et al. 1998; Holley and Arboeda-Flórez 1997) and that while the proportion of elderly homeless persons may be relatively low, the numbers are increasing. Older shelter users (aged 55 and over) in Bakersfield, California, were asked

about the duration of their current homelessness; older shelter users had an average of 742 days compared to 338 days for younger users (Hecht and Coyle 2001). Analysis of homelessness in Great Britain found that three years after the peak in the homelessness crisis in 1992, housing practitioners, "were, at an anecdotal level, beginning to remark that although numbers were decreasing, the proportion of older people claiming to be homeless and vulnerable due to age, was, if anything, on the increase…" (Hawes 1999). A one-night survey in Boston shelters found that 53 percent of the older adults had been homeless for more than two years. A follow-up survey a year later not only found more older adults, but the proportion who had been homeless for two or more years had increased, and health problems had intensified for this group. In the first survey, 76 percent suffered from at least one impairment; a year later, this proportion had risen to 91 percent. A further follow-up study in 1999 revealed another 10 percent increase in the homeless population (Gibeau 2001).

The duration of homelessness among persons aged 50 and over has been linked to a lack of services for this group. In London, England it was found that there were three times as many older persons, 50 years and over, in first-stage hostels than there were young persons, attributed in part to their long periods of stay without resettlement. The study also found that the proportion increased with age. "Although this is partly by virtue of age, it demonstrates the absence of effective resettlement programmes for older homeless people: 105 residents aged 50 years and over had remained in their hostel for more than 10 years, including several for at least 20 years and two for over 60 years…" (Crane 2001). Furthermore, compared to younger homeless people, the elderly were found to be accommodated in larger hostels with more than 100 beds. In his review of programs and policies in the US, Britain, Sweden, and Denmark, Lipmann found that few services were targeted at the elderly homeless. "Rarely did I see the problems of the elderly homeless being addressed through the mainstream aged care system: instead they are seen as part of the general homeless population. Consequently, services to the elderly homeless are, in nearly all cases, based in

night shelters or day centres. These centres are frequently dangerous and violent places which are totally inappropriate places to base services to such a vulnerable group." (Lipmann 1995)

Data on resettlement, which is relatively scarce, indicate that sustaining permanent housing for this population may be difficult. One UK study found that "over half of those who achieve resettlement become homeless again and, oddly, include people who, despite having a place to live, resort back to street life…" (Hawes 1999). One reason for this may be that the "support" component of the re-housing strategy may be inadequate or badly designed.

The prevalence of mental health problems among the elderly homeless may be another factor related to the persistence of homelessness, since mental illness "distorts their perceptions of reality, influences their capacity to seek and accept services, and thus helps to sustain homelessness" (Crane 2001).

Victimisation and vulnerability among elderly homeless persons

A recurring observation that emerges from research into the elderly homeless is their vulnerability to victimisation and the consequential isolation and need for safety and protection of the elderly homeless population (Vermette 1994; Tully 1994; Kutza and Keigher 1991; Martin 1990). Tully (1994), in discussing poverty as a causal factor in elderly homelessness cites studies that found that "the victimisation of both elderly men and women by other homeless persons robs them of what little income they do have". Part of their vulnerability may be related to the ageing process itself: elderly homeless persons were found to need support because their impaired judgement "may lead to financial mismanagement, eviction, or exploitation of their property by others; furthermore, low income, poor health, and lack of social resources may preclude many options once a residence is lost" (Kutza and Keigher 1991). In a four-city study in the UK, only 12 percent of elderly homeless persons were found to use services such as day centres and soup kitchens; this proportion was even lower for

women. Reasons included confusion and unawareness of location of services, as well as paranoia and delusional thinking about the services and staff (Crane 2001).

Victimisation is found to be both criminal and stigmatizing in nature. Referring to one study Tully (1994) concludes, "The environment in which these individuals exist is hostile, speeds up the ageing process and provides little opportunity for adequate and proper hygiene and health care". Tully also found that "the elderly homeless are frequent targets of violence. Their decreased physical abilities, low-self-esteem and difficulty defending themselves makes them easy targets for younger homeless, teens and other individuals." (Tully 1994). In the US, elderly homeless persons were found to avoid using services and contact with the 'system' "because they are chastised; are made to feel inferior; and cannot tolerate the 'rules', long lines, long waits, crowded shelters, lack of staff, inconsistent advice, loss of independence, and being made to feel as if they have been stripped of status, dignity, and self-esteem" (Bottomley et al. 2001).

The avoidance of services also leads to rough sleeping and an underestimation of their numbers. In the study of four UK cities, persons were found "sleeping in obscure places such as in rubbish skips, graveyards and bushes. Some go to great lengths to conceal their existence." (Crane 1999) Social isolation is another trait found in many studies (Crane 2001; Bruckner 2001; Vermette 1994).

Shelterisation

Some research suggests that living in shelters becomes a lifestyle that is difficult to leave (Gibeau 2001; Cohen et al. 1997): shelter users become "shelterised". Shelters have been seen as "total institutions" [4] which impose "such abnormal constraints on the resident that a civil life itself is abnormal" (Keigher 1992). "The longer an older adult is in a shelter, the longer it takes to leave. Some elders even come to see the shelter as a home" (Bottomley et al. 2001). Leaving a

[4] Elaborated by Goffman in his study *Asylums*.

shelter can create significant anxiety once the person has "adapted to a housing crisis by routinely using a shelter, learning what the routine is, establishing links to the staff, and internalizing the flow of life in a way that soon becomes a lifestyle" (Gibeau 2001). Other adaptations to shelter life include "learned helplessness" and "personality and social interactions" that make "escape" unlikely (Cohen 1999). In the UK, studies found that rough sleepers appear to use hostels as a respite, but not as a step towards resettlement (Randall and Brown 2000).

While this may be an explanation to the duration of homelessness among elderly persons, especially those who have been homeless for many years, the literature does not reveal many explanations of the causes of chronicity, nor of solutions. On the contrary, other research into homelessness indicates that many subgroups of homeless persons, some with high support needs and long periods on the streets, can be successfully re-housed (e.g. Busch-Geertsema 2000; Shinn and Baumohl 1999; Metraux and Culhane 1999).

4. HEALTH

Physical health and homelessness – all age groups

A recent literature review of health and homelessness in Canada (Eberle et al. 2001) reveals that homeless persons are more likely to report themselves in fair or poor health than the general population. Homeless persons have health problems similar to the general population, but at a much higher rate. There is also a strong connection between homelessness and mental health: it is estimated that about one third of homeless persons suffer from mental illness. The result is that "one of the costs of being homeless' in America is losing roughly 20 years of life expectancy…" (Eberle et al. 2001).

Homeless persons are likely to die of preventable causes. A study in

Philadelphia found that their age-adjusted mortality rates were nearly four times that of the general population, with leading causes including injuries, poisoning, liver disease (Hibbs et al 1994). In New York City, mortality rates among homeless persons were found to exceed those in other American cities, especially among older homeless men and women (Barrow et al 1998). Causes of death seem to vary according to age group. A study of homeless adults in Boston found that homicide was the leading cause of death in 18-24 year olds, AIDS in 25-44 year olds, and heart disease in 45 to 64 year olds (Hwang et al. 1997).

Mortality rates are found to be lower in Canada, related to lower rates of homicide and HIV infection and perhaps the presence of universal health care (Hwang 2001). Nonetheless, up to 40 percent of homeless persons in Canada [??] have been found to suffer from chronic health problems that include heart disease, emphysema, diabetes, high blood pressure and musculoskeletal disorders. A substantial number have multiple diagnoses, and HIV/ AIDS is more prevalent than in the general population (Eberle et al. 2001). Violence is a constant threat. A survey in Toronto found that 40% of homeless individuals had been assaulted and 21% of homeless women had been raped in the previous year. In the US, homeless men are about 9 times more likely to be murdered than their counterparts in the general population." (Hwang 2001).

Bottomley et al. (2001) in their examination of shelter life and elderly homeless persons, underlined the difficulty of integrating health care and homelessness. The complications that emerge from shelter living have an impact on health. Sleep deprivation is a problem (Eberle et al. 2001; Bottomley et al. 2001) as are poor diets (Crane 1999), although a study in Glasgow found that "those in the older age groups appeared to have a better balanced diet, with 89% eating some form of protein-rich food and 56% eating some fruit or vegetable" (Kershaw et al. 2000). Minor "annoyances" such as access to toilets when needed, especially when public buildings are closed, can become serious problems and "dozens of

remedies routinely available to most people, such as bed rest, remaining off one's feet, bathing, and using a vaporizer, are typically out of reach for a homeless individual. Money can be a major barrier: paying up front may be required for medications, supplies, dental care and rehabilitation. Following a diet and storing medicine can be difficult, if not impossible" (Kushner 1998). Many homeless persons must get up and leave the shelter during the day regardless of how they are feeling or of the weather outside (Bottomley et al. 2001). They may have to walk miles each day while shelters are closed, "…they are "often 'moved on' if they occupy seats at railway stations or in cafes, and wander around the streets at night for fear of being attacked if they rest. Prolonged standing and persistent walking, sometimes in ill-fitting shoes, provokes circulatory problems…" (Crane 1999). "Proper foot care requires early detection of problems, education regarding foot hygiene and the provision of adequate shoes and socks" (Hwang 2001).

Minor ailments frequently also can become major complicated health problems (Bottomley et al. 2001). In Glasgow, almost two-thirds of homeless persons surveyed had some form of long-standing illness (Kershaw et al. 2000). Conditions such as diabetes, anaemia, and hypertension "are often inadequately controlled and may go undetected for long periods" (Hwang 2001). Compliance with a course of treatment can be difficult as well. "Without a home, compliance with a home exercise program is difficult. Without transportation, regular attendance at outpatient therapy sessions may not be possible." (Bruckner 2001). Accommodations that are cramped, overcrowded or unsanitary increase the risk of infectious disease (Crane 1999). Some studies have estimated TB infection to range from 20 times higher to hundreds of times higher than in the general population (Eberle et al. 2001).

A study of diabetes management among homeless persons in Toronto (Hwang and Bugeja 2000) illustrates the difficulties of dealing with health issues. Difficulties include the diets available at shelters, which can lead to eating

unsuitable meals or not eating much. Scheduling and logistics issues are also problematic (e.g., taking insulin, which can be further complicated when shelters do not allow possession of needles). Making appointments can be difficult, and further problems can arise due to a lack of a health insurance card or a drug benefit card. Safe storage of medications can also be a problem. The result of these difficulties is that almost half of the persons surveyed had inadequately controlled diabetes.

Mental health and homelessness – all age groups

"Homelessness is associated with demoralization, depression, loss of self-esteem, and feelings of hopelessness and despair." (Crane 2001). A study in Chicago found the highest rates of depression among homeless persons under 25 and over 45, while another study in London found that 60 percent of persons surveyed four months after admission to a program were depressed some or most of the time, and 27 percent saw their futures as hopeless and expected to be dead in 6 months. In New York City, 40 percent of older street men in the Bowery were reported depressed and nearly a third expressed a wish to die (Crane 2001).

In the US, older homeless women are found to have higher levels of serious mental illness than men (Rosenheck et al. 1999). Homeless women of all ages, however, have a higher incidence of mental illness; up to 75 percent of single women, compared to 33 percent of single men (Eberle et al. 2001). In Chicago, homeless women aged 40 and over were found to be confused and incoherent than other age-gender groups. In the UK, a four city study found that older women more likely to have mental health problems than men (Crane 2001). In London hostels, it was found that the prevalence of mental illness rose with age, ranging from 5 and 10 percent for women and men aged 20 and under and rising to 20 percent for men aged 50 and over. The sharpest increase was for women: 57 percent of those aged 50-59, and 76 percent of those aged 60 and over, had mental health problems (Crane 2001).

Alcohol consumption is a common problem of older homeless persons. In Glasgow, ”hazardous drinking” was found to increase with age: 63 percent of those aged 55 and over reported such behaviour, especially men (Kershaw et al. 2000). A four-city study in the UK, however, found that heavy drinking was not a universal problem among the elderly: 42 percent of the men and 12 percent of the women were considered heavy drinkers. More serious problems occur when heavy drinking and mental health problems are combined: these persons are particularly vulnerable to predators, and difficult to help. Their disturbed or aggressive behaviour can lead to eviction from hostels. The UK four city study found that 9 percent of women and 25 percent of the men had this combination (alcohol misuse and mental illness): 48 percent had been homeless for at least 10 years, and 26 percent more than 20 years (Crane 2001).

Physical health and homelessness – the elderly

In the UK, a study of four cities found that only 6 percent of homeless men and 21 percent of homeless women were aged 75 and over, a proportion repeated in studies of Detroit and Tampa Bay (Crane 1999). It has been proposed that one of the reasons for the “youthfulness” of homeless elderly persons is the high mortality rates of homeless people, or, because of poor health, they are moved into housing or residential facilities (Crane 1999). O’Connell et al. (1990) suggest that the older individuals who remain on the streets are there because of a process of “natural selection” and these persons are survivors who have defied the odds.”

The homeless elderly suffer from multiple health problems. A study in Boston noted four major chronic illnesses on average. “Every elderly person in this study suffered either from chronic alcohol abuse (alcohol hepatitis, pancreatitis, withdrawal seizures, or a previous detoxification admission documented in the hospital record) or from major psychiatric illness….” (O’Connell et al. 1990). A study in Massachusetts found that 91 percent of older homeless adults have one

or more physical, psychological, or addictive “impairments”, and almost 50 percent have two or more (Hamel 2001). A survey in Boston found that nearly 33 percent of homeless older persons had co-existing health and functional impairments (Gibeau 2001).

Health problems have been found to be especially prevalent among older homeless persons who sleep rough: living on the street not only causes health problems, but aggravates existing ones. “Common conditions include respiratory disorders; stomach ulcers and gastritis; circulatory problems such as oedema, leg ulcers and cellulitis, caused through prolonged standing and persistent walking; and scabies and lice.” (Crane 2001) Elderly homeless people are also found to be susceptible to infections such as gastroenteritis and tuberculosis.

Some of the difficulties of elderly homeless persons are related to the ageing process, but become especially problematic in a context of homelessness. In the US, research found that “Complications of aging may increase the stress of homelessness; for example, the decline in hearing and vision that accompanies old age may create a general lack of trust and heightened anxiety…” (Rosenheck et al. 1999). Urinary incontinence is another problem that is especially difficult in shelters and in environments with a paucity of public toilets (O’Connell et al. 1990).

Access to health care – all age groups

Access to health care is a problem for many homeless persons. In London, UK, while over half of older homeless persons admitted to a street centre had physical problems, 60 percent had no contact with a doctor for more than five years. The reasons for this included depression, low self-esteem, and fearing illness and doctors. Some did not recognise the severity of their illness and “feared being shunned by staff” (Crane 2001).

Many homeless persons do not have a regular family doctor or general

practitioner and use hospital emergency services instead (Crane 1999; Kushner 1998). Often this care is sought in a crisis situation. For example, one study found that a third of homeless persons aged 50 and over in the Bowery in New York City had been hospitalised in the last year (Vermette 1994). "Homeless people are admitted to hospital up to 5 times more often than the general population and stay in hospital longer than other low-income patients." (Hwang 2001)

Problems of access include not having a health card (Hwang 2001; Fournier 1998) and reluctance of general practitioners to register homeless persons, "particularly those sleeping rough, because they tend to have multiple health problems and are thus expensive patients, they often do not keep appointments and comply with treatment, ant they are likely to move around and not stay in one area…" (Crane 1999). A study of payment to physicians providing outreach services to homeless persons in Toronto found that they received payment for only 54 percent of patient encounters and that the encounters lasted longer than average because of the complexity of problems (Hwang et al. 2000). Other reasons for the lack of access to care include the inability to locate patients to communicate test results, the disruption that homeless persons can cause in waiting rooms, and mental illness and psychotic conditions that can get in the way of treatment (Eberle et al. 2001). In the UK, bad health also was compounded because homeless persons did not see health as a priority, they needed supervision or support to go to medical clinics, or they were "unmotivated or unable to self-medicate" (Crane 1999).

5. LONG-TERM SOLUTIONS AND RE-SETTLEMENT

Much of the literature on homelessness and policies that flow from research link the issue of homelessness to housing affordability (e.g. FCM 2000; Burt 1997; O'Flaherty 1996). Program goals generally target self-sufficiency and independence as the ultimate objective (e.g. the continuum of care approach in

the US). The literature includes descriptions of approaches or interventions that have been undertaken to deal with issues of health and homelessness or an ageing homeless population. Some of the literature describes only a very general approach to solutions focussed on older homeless persons -- for example, co-ordinating services such as outreach, health and mental health care, providing a variety of housing options near services and providing assistance with the development of social ties (Rosenheck et al 1998). Many studies point out the need for a special re-settlement approach that is targeted to the elderly, for example: age-segregated services (Tully 1994) and shelters that are appropriate for frail persons and those with restricted mobility (Kutza and Keigher 1991); “lifetime homes” to accommodate those with enduring support needs (Hawes 1999); creating a sense of community for people who have likely been isolated and untrusting; and acknowledging the “significant complexity” of finding permanent housing for people with mental health and substance abuse problems (Gibeau 2001).

An underlying question in dealing with elderly homeless persons is the ultimate goal and how to give support within a context of diminishing capacity. One study from Chicago notes “their age alone renders this group particularly vulnerable. Their options for reintegrating into the dominant social and economic structure of society are few. Their physical capacity to withstand living on the streets or in shelters is limited.” (Kutza and Keigher 1991). In London, one hostel found that 16 percent of shelter users had memory difficulties, requiring “regular assistance with everyday tasks, such as attending to personal hygiene, managing finances, and laundry. They also needed to be constantly reminded when meals were served and how to reach their bedrooms.” (Crane 2001)

A study of homeless women aged 50 and over in New York City suggested that older women had the best potential to be re-settled because; “they maintain social ties, often to kin, and their levels of alcoholism, drug abuse, and criminality are low versus homeless men and younger women…” (Cohen et al. 1997). The

residential outcomes of 201 women, 60 percent of whom had a lifetime homelessness history, were examined two years after intervention. Over half (53 percent) were no longer domiciled, and those who continued to be housed "were significantly more likely to have had a greater number of entitlements, to have more overall network members, to perceive their social contacts as being more available in times of need, to have more interconnected networks (i.e. high density), and to have more contact with community facilities and institutions". The authors conclude that the results tend to "underscore the importance of systemic factors in creating and maintaining homelessness among ageing women". (Cohen et al. 1997)

In a similar vein, two studies of health and homelessness underline systemic factors. An analysis of causes of mortality in Philadelphia concludes that financial and social barriers prevent homeless people from seeking health care. Poor working conditions and deficient resources hamper those providing care to homeless people. Therapeutic intervention is inadequate to protect homeless people from injury. Homelessness itself, rather than identifiable medical conditions, appears to be the risk factor that most needs to be eliminated in order to reduce preventable mortality." (Hibbs et al. 1994) A study of mortality in Boston closes with this statement: "The high risk for death from homicide and accidental injury is a predictable result of poverty, substance abuse, and living on the streets. Increasing the availability of adequate low-income housing could conceivably reduced this risk. Improving alcohol and drug treatment programs, however, may be a more important way to reduce injuries in the homeless population and might also help to decrease the high mortality rates that are attributed to cirrhosis and drug overdose." (Hwang et al 1997)

Long-term solutions and re-settlement of older homeless persons

Hecht and Coyle (2001), in reviewing a range of solutions to homelessness (including affordable housing, jobs and job training and assistance with personal problems such as addiction and domestic violence) find that "the discourse about

problem, solution, and practice in many cases contradicts what gerontologists have come to understand about the housing needs of older people." The continuum of seniors' housing begins with independent living and moves to increasing levels of support with modifications to services and living arrangement as health declines. "Seen from this perspective, those homeless policies and practices that begin with transitional living situations and work toward the goal of helping clients to achieve permanent independent living arrangements maintained according to a self-sufficiency model, whether because organizations carry a particular vision of what constitutes success (i.e. self-sufficiency) or because resources to provide continuing supportive services are unavailable, may have little likelihood of success in serving the older homeless." (Hecht and Coyle 2001)

Respite services

The chronicity of persons coming from hospitals (Springer et al. 1998) reveals that homeless persons are referred to shelters from hospital (11 percent of persons over 60 in Vermette 1994), and that there are significant difficulties managing illness in a shelter situation. Shorter hospital stays, result in the need for respite services. There also is need for services for persons who are not sick enough to be hospitalised but are too sick to be on the streets.

A survey of 28 projects in the US highlighted different models of respite services (McMurray-Avila 1999). One model is freestanding medical respite units that can offer substance abuse detoxification, dental care and case management. Freestanding units can be more comprehensive in the range of services provided (both medical and non-medical) and can be designed to meet special needs. These units have difficulty, however, finding adequate funding and appropriate facilities. They also face challenges related to licensing, zoning and the "NIMBY" syndrome. Another model and level of respite care is shelter-based, in which designated areas in shelters can be set aside to provide 24-hour nursing care and other support. The advantages of this model are: using the expertise of

existing programs; possible elimination of the need for special licensing; and encouragement of co-ordination and collaboration among agencies.
There is, however, the possibility of differing philosophies between shelter and health programs, possible conflict over admission control and possibly little control by the health program over health and safety issues in the shelter environment. Some respite services comprise vouchers to place clients in motel or hotel rooms. This option appears relatively low cost and easy to start up, not necessitating licensing or other regulations and allowing families to stay together. It may not be satisfactory, however, if there is no 24-hour nursing care or guaranteed meal service, and if they are situated far from service providers, leaving clients isolated. The final respite model is to contract for beds in board and care homes which offer 24-hour nursing care, meals and human contact. There is little control over the appropriateness and quality of care, and little control over health and safety issues in these situations, however, so it is difficult to assure appropriate care and liaisons to people with multiple health problems.

APPENDIX B: BIBLIOGRAPHY

Barrow, Susan M. et al. 1999 “Mortality Among Homeless Shelter Residents in New York City” *American Journal of Public Health*, Vol. 89, No. 4

Bruckner, Jan 2001 “Walking a Mile in Their Shoes: Sociocultural Considerations in Elder Homelessness” *Topics in Geriatric Rehabilitation* 16 (4) 15-27

Burt, Martha R. 1997. “Causes of the Growth of Homelessness During the 1980s” in Culhane, Dennis P. and Steven P. Hornburg. (Eds.) 1997. Understanding Homelessness: New Policy and Research Perspectives. Washington, DC: Fannie Mae Foundation.

Busch-Geertsema, Volker 2000 *When Homeless People are Allowed to Decide by Themselves. Rehousing Homeless People in Germany* Gesellschaft Für Innovative Sozialforschung Und Sozialplanung (GISS) E.V., Bremen, Germany, Contribution to Conference In Malmö, 16th November

Canadian Public Health Association 1997 CPHA 1997 Position Paper on Homelessness and Health, http://www.cpha.ca

Cohen, Carl I. 1999 “Ageing and homelessness’, *The Gerontologist*, Vol. 39, Issue 1, pgs 5-14

Cohen, Carl I. et al. 1997 “Predictors of becoming redomiciled among older homeless women” *The Gerontologist*, Vol. 37, Issue 1, pgs 67-74

Council for Homeless Persons Australia (nd) *Elderly People and Homelessness* http://www.chpa.org.au/elderly.html

Crane, Maureen 1999 *Understanding older homeless people : their*

circumstances, problems, and needs. Buckingham, England ; Philadelphia : Open University Press, Rethinking ageing series

Crane, Maureen 2001 Our Forgotten Elders: Older People on the Streets and in Hostels, St Mungo's, London http://www.mungos.org/facts/reports.shtml

Eberle Planning and Research et al. 2002 *Research Project on Homelessness in Greater Vancouver, Volume 2 Profile of Homeless and At-Risk People in Grater Vancouver*, The Greater Vancouver Regional District

Eberle et al. 2001 *Homelessness – Causes and Effects Vol. 1. The relationship between homelessness and the health, social services and criminal justice systems: A review of the literature* British Columbia Ministry of Social Development and Economic Security, and BC Housing Management Commission

Edmonton Task Force on Homelessness 1999 *Homelessness in Edmonton, A Call to Action* Housing, Community Services, City of Edmonton

Federation of Canadian Municipalities. 2000. *A National Affordable Housing Strategy*.

Fournier, Louise et al. 1998 *Dénombrement de la clientèle itinérante dans les centres d'hébergement, les soupes populaires et les centres de jour des villes de Montréal et de Québec 1996-97*. Santé Québec, 20 novembre.

Gibeau, Janice L. 2001 "Home Free: An Evolving Journey in Eradicating Elder Homelessness" *Topics in Geriatric Rehabilitation* 17 (1)22-52

Goetcheus, Janelle et al. 1990 "Convalescence: For Those Without a Home – Developing Respite Services in Protected Environments" in Brickner Philip W. et

al. (eds) *Under the safety net : the health and social welfare of the homeless in the United States* New York : Norton

Grenier, Paola 1996 *Still Dying for a Home* Crisis: London Abstract at : http://www.crashindex.org.uk/biblio.html

Hallebone, Erica 1997 “Homelessness and Marginality in Australia: Young and Old People Excluded from Independence” in *International critical perspectives on homelessness* Mary Jo Huth and Talmadge Wright (eds) Published Westport, Conn.: Praeger

Hamel, Pauline 2001 “Interdisciplinary Perspectives, Service Learning, and Advocacy: A non-traditional Approach to Geriatric Rehabilitation” *Topics in Geriatric Rehabilitation* 17 (1)53-70

Hawes, Derek 1999 “Old and homeless: a double jeopardy” in Patricia Kennet and Alex Marsh (eds) *Homelessness: Exploring the New Terrain* The Policy Press Southhampton:GB

Hecht, Laura and Bonita Coyle 2001 “Elderly Homeless” American Behavioural Scientist, Vol. 45 No 1 September 66-79

Hibbs, Jonathan R et al 1994 “Mortality in a cohort of homeless adults in Philadelphia” *The New England Journal of Medicine* Volume 331: 304-309, August 4 1994 Number 5

Holley, H.L. and J. Arboeda-Flórez 1997 *Calgary Homelessness Study, Final Report*, Alberta Health and the Calgary Homeless Initiative, Calgary

Hwang, Stephen W 2001 “Homelessness and Health” *Canadian Medical Association Journal*, Jan 23; 164 (2)

Hwang, Stephen W and Ann L. Bugeja 2000 “Barriers to appropriate diabetes management among homeless people in Toronto ” *Canadian Medical Association Journal*, July 25; 163 (2)

Hwang, Stephen W et al. 1997 “Causes of Death in Homeless Adults in Boston” *Annals of Internal Medicine* 15 April 126:625-628

Hwang, Stephen W et al. 2000 “Physician payment for the care of homeless people ” *Canadian Medical Association Journal*, July 25; 163 (2)

Keigher, Sharon M. 1992. “Rediscovering the Asylum.” *Journal of Sociology and Social Welfare* 19 (4): 177-197

Kershaw, Ashley, Nicola Singleton and Howard Meltzer 2000 *Survey of the health and well-being of homeless people in Glasgow*, Summary Report, Office for National Statistics London

Kushner, Carol 1998 “Better Access, Better Care, A Research Paper on Health Services and Homelessness in Toronto” *Report to the Mayor’s Homelessness Action Task Force, Taking Responsibility for Homelessness*, Background Papers Vol. I

Kutza, Elizabeth A. and Sharon M. Keigher 1991 “The Elderly ‘New Homeless’: An Emerging Population At Risk” *Social Work*, Volume 36, Number 4

Lipmann, Bryan 1995 *The Elderly Homeless, An investigation into the provision of services for frail, elderly homeless men and women in the United States of America, Britain, Sweden and Denmark,* Wintringham, Melbourne, Australia

Martin, Marsha 1990 “The Homeless Elderly: No Room at the End” in Harel, Zev,

Phyllis Ehrlich, and Richard Hubbard (eds) *The Vulnerable aged : people, services, and policies* New York : Springer Pub. Co.

McMurray-Avila, Marsha 1999 *Medical Respite Services for Homeless People: Practical Models*, National Health Care for the Homeless Council http://www.nhchc.org/Publications/MedicalRespiteServices.pdf

Metraux, Stephen and Dennis P. Culhane 1999. "Family Dynamics, Housing, and Recurring Homelessness among Women in New York City Homeless Shelters." *Journal of Family Issues* 20: (3) 371-396

O'Connell, James J. et al. 1990 "The Homeless Elderly" in Brickner Philip W. et al. (eds) *Under the safety net : the health and social welfare of the homeless in the United States* New York : Norton

O'Flaherty, Brendan (1996) *Making Room: the Economics of Homelessness*. Cambridge, MA: Harvard University Press.

Plumb, James D. 2000 "Homelessness: reducing health disparities " *Canadian Medical Association Journal*, July 25; 163 (2)

Policy Research Associates, Inc. 2001 *Bibliography #5 Health Care Issues for Elderly Homeless People*, Health Care for the Homeless Information Resource Centre, Delmar, New York

Post, Patricia A. 2001 *Casualties of complexity: Why Eligible Homeless People Are Not Enrolled in Medicaid*, National Health Care for the Homeless Council http://www.nhchc.org/Publications/CasualtiesofComplexity.pdf

Randall, Geoffrey and Susan Brown. 2000. *Homes for street people: An Evaluation of the Rough Sleepers Initiative. Housing Research Summary*. DETR website.

Rosenheck, Robert, Ellen Bassuk, and Amy Salomon 1999 “Special Populations of Homeless Americans” In Linda Fosburg and Deborah Dennis (eds.) *Practical Lessons: National Symposium on Homeless Research*. Prepared for US Department of Housing and Urban Development and US. Department of Health and Human Services.

Shinn, Marybeth and Jim Baumohl. 1999. ‘Rethinking the Prevention of Homelessness.’ In *Practical Lessons: National Symposium on Homelessness Research*.

Springer, Joseph H. et al. 1998 “A profile of the Toronto Homeless Population” *Report to the Mayor’s Homelessness Action Task Force, Taking Responsibility for Homelessness*, Background Papers Vol. II

Statistics Canada 2002 *2001 Census: Collective Dwellings*, Catalogue no. 96F0030XIE2001004, November 5
http://www12.statcan.ca/english/census01/Products/Analytic/

Tully, Carol T and Sharon Jacobson 1994 “The Homeless Elderly: America’s Forgotten Population” *Journal of Gerontological Social Work* Vol. 22 (3/4)

Vermette, Guy, 1994 *L’itinérance Chez les Personnes Âgées*, Régie régionale de la santé et des services sociaux de Montréal-Centre, Montréal

APPENDIX C: KEY INFORMANT INTERVIEW GUIDES

Questions for Long-Term Care Providers

1. What is the situation in your region, regarding availability of residential long-term care beds? (Just a snapshot – no hard data required.) What about availability of affordable (subsidized) supportive housing and assisted living?

2. What is the situation in your region, regarding the number of homeless people seeking shelter and other services? To the best of your knowledge: Who are they? Where do they live? What are their unmet needs? (Just a snapshot – no hard data required.)

3. Regarding eligibility requirements for residential long-term care in your province:

a) Would you highlight for me the most important or <u>most heavily weighted eligibility criteria</u> for residential placement?

b) What about /supportive housing/assisted living? Do applicants get processed through the same channels? Are they assessed using the same tools?

4. What are the barriers to accessing residential long-term care (including supportive housing and assisted living) for <u>homeless</u> people who are chronically ill and/or elderly? Is access to residential long-term care (including supportive housing and assisted living) a problem:

a) Because the homeless are not part of "the system" – they are not "clients" of the health care system? How can this barrier be overcome?

b) Because they cannot be found easily, to do assessments, follow-up meetings,

etc.? (That is, the assessment and placement process does not fit their reality?) How could this barrier be overcome?

c) Because they choose not to become part of "the system" and so resist attempts to place them in a supervised environment? How could this barrier be overcome?

d) Because they do not have health insurance care cards and numbers? How could this barrier be overcome?

e) Because there are very few links between the long-term care system/practitioners and the shelter/homeless system/practitioners? How could this barrier be overcome?

f) Because one of the criteria for staying in residential or congregate care is behaving in a way that does not disrupt other residents, and experience has shown that homeless people often cause difficulties in this regard? How could this barrier be overcome?

g) Because there is such a demand for available "beds" that facility administrators can be choosy, and they choose not to admit potentially "difficult" residents? (Or there is such demand for subsidized supportive housing/assisted living that sponsors can be choosy?) How could this barrier be overcome?]

5. What resources and supports do you think are needed to provide residential long-term care (or supportive housing or assisted living) to chronically ill and/or elderly homeless people?

a) First, what supports would you need, in your role (e.g., if you are placement co-ordinator or case manager)?

b) Second, what supports would residential facilities need to be able to accommodate and provide care to chronically ill and/or elderly homeless people?

6. There are basically two approaches, that we know of, for providing residential long-term care to chronically ill and/or elderly homeless people:

- one option is to create a special program for this client group within an existing mainstream residential facility (where, for example, one wing, or two double rooms are "dedicated" to serving this client group);

- the other option is to create a special facility specifically designed for this client group. It is typically attached or adjacent to an existing emergency shelter.

a) This may be a question that you do not feel qualified to answer, but please give an opinion, even if you do not have any experience with homeless clients. Which of the two models - the integrated approach, or the segregated approach - would work better, in your opinion? Why?

7. Could you suggest some of the features that you think would be suitable in a residential long-term care, or supportive housing or assisted living setting for (formerly) homeless elderly or chronically ill people who need 24 x 7 support and supervision?

a) What location and site characteristics?
b) What kind and size of housing/accommodation?
c) What services?
d) What kind of staff?
e) What style of service or philosophy of service?

Questions for Shelter Providers

1. What is the situation in your region, regarding elderly (over 50 year old) homeless persons living in shelters or on the streets?
   - Do you have a sense of the proportions of men and women?
   - Are their numbers increasing, decreasing or remaining the same? (Just a snapshot – no hard data required.)

2. What is the situation in your region, regarding homeless persons with chronic illnesses living in shelters or on the streets?
   - Do you have a sense of the proportions of men and women?
   - What types of chronic illness do they have?
   - Are their numbers increasing, decreasing or remaining the same? (Just a snapshot – no hard data required.)

3. Are there particular problems that elderly persons, compared to younger ones, encounter because they are homeless?
   - What happens to an elderly person with mobility problems?
   - What happens to persons who have memory problems?

4. Are there particular problems that chronically ill persons, compared to healthier ones, encounter because they are homeless? For example,
   - What do they do when they do not feel well enough to leave the shelter during the day?
   - Where do they go when they are released from hospital – for example, what do they do if they require medical supervision or bed rest?

5. What are the options for elderly persons when they become too frail to live in the shelter or on the street?
   - Who does the assessment of their need?
   - What are the next steps in placing them?
   - Are there sufficient places given the need?

6. Have you ever tried to place an elderly homeless person in residential long-term care? What happened?

7. Do you think that mainstream residential long-term care is suitable for persons who have been homeless? Are there behavioural or other problems that emerge when persons are placed in care?

8. There are basically two approaches, that we know of, for providing residential long-term care to chronically ill and/or elderly homeless people:

   - one option is to create a special program for this client group within an existing mainstream residential facility (where, for example, one wing, or two double rooms are "dedicated" to serving this client group);
   - the other option is to create a special facility specifically designed for this client group. It can be attached or adjacent to an existing emergency shelter.

- Which of the two models - the integrated approach, or the segregated approach - would work better, in your opinion? Why?

9. Could you suggest some of the features that you think would be suitable in a residential care setting for (formerly) homeless elderly or chronically ill people who need 24 x 7 support and supervision? For example:
   a) What location and site characteristics?
   b) What housing type and size/scale?
   c) What services?
   d) What kind of staff?
   e) What style of service or philosophy?

APPENDIX D: LIST OF KEY INFORMANTS

John Almeda
Old Brewery Mission
Montreal QC

Joyce Brown
Toronto ON

André Charbonneau
Maison du Père
Montreal QC

Joan Dawkins
Executive Director
Mainstreet Project
Winnipeg MB

Linda Day
Institute of Aboriginal Peoples' Health
Canadian Institutes of Health Research (CIHR)
Ottawa ON

Louise Dercole
Case Manager, Three Bridges Health Unit
Vancouver BC

Suzanne Gervais
Counsellor
Centretown Community Health Centre
Ottawa ON

Claude Jodoin
Accueil Bonneau et Maison Claire Ménard
Montreal QC

Irv Kirstein
Ministry of Health and Long-term Care
Province of Ontario
Toronto ON

Stefanie Krasij
Women's Residence
Toronto ON

Myles Livingston
Winnipeg Housing and Homelessness Initiative
Winnipeg MB

Warren Matheson, ED
Veterans' Manor
Downtown East Side, Vancouver BC

Monique Maurice
CLSC Les Faubourgs
Montreal QC

Karen O'Shannecery, ED
Lookout Shelter
Vancouver BC

Johanne Paquette
Le P.A.S. de la Rue
Montreal QC

Greg Richmond, Manager
Triage Shelter
Vancouver BC

Francine Rioux
Résidence du Vieux Port
Montreal QC

Ross Smith
Public Health Nurse
City of Toronto ON

Teresa Snider
Outreach Worker
Seniors Housing Information Program
Burnaby BC

Karla Staff
Northern Health Authority
Prince George BC

Janis Thorkelsson
Mental Health Consultant
Vancouver Island Health Authority
Victoria BC

Kip Veale
Health and Community Services
Whitehorse YK

APPENDIX E: DETAILED CASE STUDIES

Case Study #1: Hospice for the Homeless, The Mission - Ottawa, Ontario

Physical Description
The Hospice for the Homeless opened up in May 2001 in downtown Ottawa. It is part of a new 4-story building that also contains 21 long-term supportive housing units. It is operated and attached to the Mission, a multi-faceted service for homeless persons that has been in existence since 1906.

The Mission offers a shelter (185 beds and 45 additional emergency floor mats), meals, a drop-in centre, a clothing program, a life skills program as well as a health clinic and mental health services.

The Hospice has 14 beds.

Residents/clients
Homeless persons (men and women) or those at risk of becoming homeless who are in need of palliative care, including persons with HIV/AIDS, terminal health problems resulting from addictions, chronic hepatitis, etc.

Referrals come from hospitals and agencies that work with homeless persons.

Services
The Hospice offers 24-hour palliative care. Doctors and nurses (one full-time nursing co-ordinator and two weekend nurses) are available at all times as well as full-time care workers (13 workers). There is also a Hospice Services Co-ordinator. Volunteer contributions range from massage therapy to physiotherapy and spiritual support.

Clients can come and go as they wish and friends and family are welcome.

The average length of stay is about 100 days. Some clients are discharged or transferred to another program but most die at the Hospice.

Development History
In 1999 the Regional Municipality of Ottawa-Carleton (now the City of Ottawa) undertook a community consultation process on homelessness that resulted in an action plan (Creating Community Solutions). The plan identified the necessity to increase community capacity to provide addiction services, home care, and palliative and long-term care for persons who are homeless or at risk. An ad hoc group was formed to explore ways in which the health-related recommendations of the action plan could be implemented.

The Inner City Health Project that emerged is made up of representatives from shelters and services for homeless persons, inner city primary health care facilities, a homecare organisation, the City of Ottawa, the University of Ottawa and the Ottawa Hospital. The work of the Inner City Health Project includes

providing and co-ordinating services to homeless persons, including convalescence and short term care (up to 20 beds at the Salvation Army Booth Centre) and the palliative care component at the Mission.

The need for palliative care came from the observation that homeless persons were facing terminal illnesses and dying alone (estimated at 50/year in Ottawa). Needed for this population was an approach that emphasised freedom, flexibility and care. Many homeless persons had difficulty fitting into existing palliative care systems and the existing systems have difficulty dealing with the multiple and diverse problems of homeless persons. For example, addictions among homeless persons are a major barrier to mainstream palliative care facilities and no facilities that take a harm reduction approach exist.

The project took eighteen months to develop and was undertaken in collaboration with CMHC (Residential Rehabilitation Assistance Program), the Federal government (SCPI funding), the Community Foundation of Ottawa, the Crabtree Foundation, and private donors. The new building attached to the Mission was constructed at a cost of $1.9 million.

The annual operating expenses are over $700,000, of which about $664,000 are direct costs. The rest are indirect costs – both volunteer contributions and donated equipment and supplies. The direct costs are funded by the City, the United Way and donations.

Overall Philosophy
The guiding principles include comprehensiveness of care, innovation, collaboration and communication between levels of government, various government departments, between service providers and persons who are homeless, accessibility and flexibility to accommodate individual circumstances, community involvement, a harm reduction approach, and integration with existing services. Fundamental to the Inner City Health Project is treating clients with respect, compassion and dignity. The project is committed to excellence in the provision of care, the responsible use of resource, to teaching, learning and research and to ending homelessness in the community.

Concerns and Challenges
The main concern is providing the best care possible. Because of Inner City Health Project constraints there are not enough client care workers per shift to oversee the care of all the clients (ideally at least 2 workers). This is especially of concern on the evening and overnight shifts when there is no nurse on the premise, leaving one client care worker.

Another concern is the lack of available transportation and drivers or persons to accompany clients to various appointments.

Lessons

- It is important to stay focussed on the client.
- Partnerships and a supportive community are essential.

Successes

- This is the only project dedicated exclusively to palliative care for homeless persons in Canada.
- The World Health Organisation presented the Ottawa Inner City Health Project and the Mission's Hospice for the Homeless an Innovative Project Award.
- There is a waiting list of volunteers.

Contacts

Diane Morrison
Executive Director
The Mission
35 Waller Street
Ottawa, Ontario K1N 7G4
Phone:(613) 234 - 1144
Fax:(613) 234 – 2813
Email: mission@ottawamission.com
http://www.ottawamission.com/

Case Study #2: Seaton House Infirmary - Toronto, Ontario

Physical Description
The Infirmary is one of the many services that is offered by Seaton House.[5] It is located within the main downtown building and has 35 beds with 24-hour staff.

Residents/Clients
Seaton House clients as well as referrals from the community and St. Michael's Hospital.

Services
The Infirmary receives men who have been discharged from hospital but who are not yet ready to cope with life on the street, who have health care needs that don't warrant transfer to another facility, or whose transfer would be disruptive to the case management plan. The unit cares for men with uncontrolled diabetes, pneumonia, schizophrenia, liver disease, cellulitis, cancer and severe depression. Palliative care is available when needed.

St. Michael's Hospital, located in downtown Toronto, provides physicians, and University of Toronto Family Medicine residents do a rotation at Seaton House. Seaton House provides other staffing.

The model is based on a harm reduction approach focussing on reducing the problems associated with substance abuse without reducing or eliminating the substance abuse itself. Abstinence models have often failed for clients of Seaton House and the Infirmary. Many clients have been forced to leave hospitals against medical advice because they needed to get a drink. The Infirmary will provide alcohol or other substitutes to provide for the best health outcomes.

---

[5] Seaton House has been located in an inner city neighbourhood where the homeless population has traditionally resided, since 1934. It is close to many services – hospitals, health centres, and drop-in centres.

It includes a 140-bed Long Term Program on the fourth floor of the main building for men over 50 years and for younger men with significant physical or mental health problems. The area includes semi-private rooms and wards (up to six bed), two TV rooms (one for smokers), a library/computer room, recreation area, balcony, room/office to meet with caseworkers, nursing station, front office/reception, room/office of two housing counsellors, room for Shared Care mental health outreach team, front lobby, balcony, kitchen/meeting space for visiting service providers, large dining room downstairs.

Seaton House also includes a "Wet" Shelter (The Annex) with an Infirmary, a shelter program for chronic cocaine users (O'Neil Crack Cocaine Program), and an overnight shelter.

Development History
The construction of the Infirmary began in 2001 as a response to the need for shelter-hospital integration between Seaton House and St. Michael's Hospital.

The Rotary Club of Toronto provided $350,000 for equipment and renovations, while the $150,700 from the Federal National Homelessness Initiative (the Supporting Communities Partnership Initiative – SCPI), was given to improve the co-ordination and integration of services between the family practice residency program at St. Michael's Hospital and Seaton House.

Concerns and Challenges
Because of staffing difficulties the Infirmary is not operating at full capacity and about 20 beds are currently used.

Lessons

- The development of the Infirmary is the result of constant creative responses to needs.
- The project emphasises the need to be advocates in regards to services for the men.
- Working in partnership is critical.

Successes
The Infirmary is one of the pieces of an integrated approach to health care that has been developed by Seaton House, St. Michael's Hospital, the University of Toronto and other partners such as the Rotary Club of Toronto.

Contacts
Arthur Manuel
Program Manager
Seaton House
339 George St.
Toronto, Ontario
M5A 2N2

Tel: 416-392-5537
Fax: 416-392-5549.
Email: amanuel@toronto.ca

Case Study #3: Integration of Health and Shelter - Toronto, Ontario

Physical Description
Seaton House[6] and St. Michael's Hospital, situated in downtown Toronto, have worked to better integrate the delivery of health care to homeless persons. St. Michael's, because of its location, has developed a number of services addressing the needs of homeless persons. These include:

- The Rotary Transition Centre which is located within the hospital Emergency Department. It is a place of respite for homeless persons where they can receive not only medical attention but also they can shower, eat, and have their clothes washed.

- The Homeless Person's Protocol directs the course of immediate treatment as well as preventative medical interventions (e.g. tuberculosis screening and skin assessment), contact with social workers and community services. Often these persons do not have OHIP (Ontario Health Insurance Plan) but are treated nonetheless. (According to research conducted by the Inner City Health Research Unit about 50% of men treated in hostels and shelters do not have OHIP.)

- The Psychiatry Shelter Outreach Program provides psychiatrists and those in training to clients in shelters.

- The partnership with Seaton House allows patients in need of further care after discharge to be transferred to the Infirmary. (See Case Study #2.)

Besides the development of the Infirmary, the partnership between Seaton House and St. Michael's Hospital, as well as the University of Toronto Faculty of Medicine, has allowed other services and approaches to be developed. These include:

- The Inner City Health Project Concept. This is a three-tiered approach which gives clients access to primary multidisciplinary care in shelters (e.g. counsellors, shelter workers, nurses and physicians), an integration of services from various agencies working in partnership (e.g. creation of a centralized client-controlled multidisciplinary computer record), and helping clients strengthen and develop links with community agencies outside of the shelter system (e.g. access to health care and legal aid services ready to accept vulnerable clients with multi-system problems such as serious mental illness, chronic and acute physical illness, etc.).

[6] See Case Study #2 for a description of Seaton House.

- Palliative care services in the Infirmary that allow clients to die in a supportive and familiar environment.

- The development of a Fusion of Care model, which incorporates an integrated team approach, a single administration (Medical Director and MDs that report to both St. Michael's Hospital and Seaton House), and a single information system (e.g. a common chart) that permits complete sharing of information. The model also includes ongoing research and evaluation through academic centres (e.g. University of Toronto), a harm reduction approach, continual integration of additional agencies, acting as a teaching centre, and ongoing advocacy for community development to eradicate systemic homelessness.

- A Shared Care program through the Centre for Addiction and Mental Health (CAMH) that includes nurses, outreach workers, and a psychiatrist.

- Discharge planning from the hospital is undertaken by both St. Michael's staff and a representative from Seaton House.

- Seaton House is included in the process of provincial accreditation of St. Michael's hospital – ensuring ongoing response to needs of homeless persons.

Contacts
Arthur Manuel
Program Manager
Seaton House
339 George St.
Toronto, Ontario
M5A 2N2

Tel: 416-392-5537
Fax: 416-392-5549.
Email: amanuel@toronto.ca

Case Study #4: Hazelton Residence – Vancouver, British Columbia

Physical Description

The Hazelton Residence, one component of the Lookout Emergency Aid Society of Vancouver, is a three-storey brick and siding building, located in the Downtown Eastside of Vancouver, British Columbia -- "the poorest postal code in Canada", the "dumping ground for the hard-to-house and mentally ill in BC". It was located there because it is familiar territory for the clients of Lookout (initially, the target population was elderly, chronically homeless alcoholics). It was understood that providing supportive housing options to the hard-to-house population frees up emergency shelter beds for the temporarily homeless. The building includes reception, a lounge with computers, offices for visiting service providers, a cafeteria that seats 42, emergency shelter for 42, and 39 rooms (14-16 square meters) for elderly and/or chronically ill homeless persons. Toilets and bathing facilities are separate. The focus of this case study is on the 39 rooms dedicated to persons who need considerable support and care, and their occupants.

Residents/Clients

There were 39 tenants in Hazelton Residence in March 2003, mostly males, 87 percent Caucasian, 10 percent Aboriginal, 3 percent Asian, ranging in age from 36 to 80. Length of stay varies from a few months to 13+ years. Almost all receive a disability pension. Diagnoses include mental illness (62 percent), alcohol and drug abuse, as well as a variety of physical illnesses related to "living rough" and, in some cases, AIDS. Only three residents are physically impaired. Almost three-quarters of residents do not engage in any outside activities. Within the last 10 years, there have been more tenants with AIDS, Hepatitis C, dementias and mental illness. The care needs among applicants are higher each year. Residents moved there because there "were no other options, short of perishing under a bridge or living in a long-term care facility", partly because this population is seriously lacking in life skills.

Services

Hazelton Residence is licensed as "Special Needs Residential". Services provided on-site include financial management, medications management, escorts to appointments, crisis intervention, referrals, advocacy and liaison to other providers, by means of Tenant Support workers who are on-site 7 AM to 11 PM daily. Tenant Support Workers tend to be from the addictions or mental health fields. Visiting service providers include a doctor (a specialist in AIDS) who visits twice weekly, Home Nursing (7 days/week), psychiatrists and mental health workers from the regional mental health team, Home Support 45 hours/week (blocked, with continuity in staffing), and Occupation and Physical Therapy, Podiatry and Nutrition assessments as needed. Nearby services include a downtown health clinic and the community cafeteria at the Veterans' Manor, two buildings away. Funding for services comes from the regional health authority and the City of Vancouver. Tenants' medications are free, and there is

a heavily subsidized flat rate of $125/month for three meals and two snacks per day per resident.

Development History
The Hazelton Residence was built in 1981, in recognition that there was the need for a bridge between shelter and permanent housing. It was originally intended as transitional housing, but evolved into assisted living as the care needs of homeless people became more complex. The philosophy was to fill a niche, and to provide "services to folks who have the fewest options". Funding was provided by CMHC, in the form of a $4M loan under the Non-Profit housing program. The annual operating budget is approximately $2M for the Hazelton Residence and the 42-bed shelter, combined. Service costs are covered by the regional health authority.

Concerns and Challenges
The most difficult challenge of this project is balancing shelter and long-term care in the same building. Emergency shelter users, typically younger people who are drug abusers, prey on the more vulnerable tenants who are receiving care. Another concern is that because the whole building is licensed (Special Needs Residential), it "is difficult to maintain a homey environment". Unmet needs in the community for elderly and/or chronically homeless people are: lifeskills development opportunities, pre-employment programming, psychotherapy, "and, of course, more supportive housing and assisted living!"

Lessons
- There should be physical separation between an emergency shelter and long-term care components of a community-based supportive housing project.
- There should be a reception area, and security services 24 x 7.
- It is very important at the design stage to provide plenty of space for 1) service providers' offices, 2) tenants' social interaction, and 3) storage.
- Each resident's room needs a 2- or 3-piece bathroom and resilient surfaces/materials throughout.
- There should be a functional, communal "teaching" kitchen where tenant support workers can coach tenants in meal preparation, food storage, etc..
- Medications administration is a critical service to offer this client group.

Successes
The most outstanding successes are:
- Seeing "people alive, not living under bridges or bouncing from a hotel to a shelter to emergency… keeping a roof over their heads."
- "Seeing people move up in terms of their housing" from Hazelton Residence to social housing.
- The positive social impacts: reduction in the use of hospital services, jails and emergency shelters resulting in savings for the taxpayer.

Contacts
Joyce Wilson, Residential Services Manager, Lookout Society, 429 Alexander Street, Vancouver, BC V6A 1C6, Telephone (604)255-0340, Fax (604)255-0790, Email: joycewilson@lookoutsociety.bc.ca

Tenant Support Workers, 346 Alexander Street, Vancouver BC V6A 1C3 Telephone (604) 681-9873.

Case Study #5: Proposed Transitional Housing Project for Aboriginal People with Mobility Disabilities - Winnipeg, Manitoba

Physical Description
Funding for this project has been requested from the Federal National Homelessness Initiative (the Supporting Communities Partnership Initiative – SCPI). The Canadian Paraplegic Association and Ten Ten Sinclair Inc. in Winnipeg Manitoba have developed the proposed project.

The project is a transitional housing facility (length of stay will be one and a half to three years) that will address the needs of Aboriginal persons in a culturally sensitive manner and will be owned and operated as an Aboriginal facility.

The final site has not been identified but the project will have about 20 units: 25 percent 1 bedroom (5 units); 50 percent 2 bedrooms (10 units); 20 percent 3 bedrooms (4 units); and 5 percent 4 bedrooms. Common areas will include a dining room and food preparation area; a physical/occupational therapy room; guest/attendant rooms; offices; meeting room; and outdoor children's play area.

The location should be near shopping, transportation, medical services, schools and professional services. The organisations involved in the project development prefer a location away from the inner city.

Residents
The clients will meet the following criteria:

- Be experiencing absolute or relative homelessness or be at risk of becoming homeless.
- Be Aboriginal and have significant mobility disabilities - primarily spinal cord injuries.
- Not currently receiving appropriate services and support from traditional or mainstream housing programs.
- Have fallen through the "cracks" of various social service agencies and assistance programs.

The facility will include both individuals and, where needed, their immediate families.

Services
The services will include response to post-trauma/recovery needs. The programming will offer peer support and the use of a holistic and traditional healing model. This will include spiritual and emotional counselling, collective healing ceremonies, 24-hour attendant care (dressing, bathing, etc.), and physical and occupational therapy. Other services will include addictions counselling, and lifeskills and money management training. Outreach will help co-ordinate services for those ready to move into permanent housing or for clients not residing in the facility.

Development History
The Canadian Paraplegic Association in Manitoba has been offering services to the Aboriginal community since the 1980s. The work of the rehabilitation counsellors is one of high burnout because it is often crisis management and because, in the last few years, finding appropriate and affordable housing has been increasingly difficult. Often the housing available is not adapted or it is in neighbourhoods that are detrimental to clients (e.g. with high levels of gang activity). Many of the future residents of this project have come to Winnipeg from reserves, often with little or no family and social supports.

Ten Ten Sinclair, the other partner in this project, promotes and develops independent living for people with physical disabilities. The experience of Ten Ten Sinclair is that some residents are not able to cope with the responsibilities and behaviours required for their transitional housing (e.g. signing a lease and an agreement) and some residents are evicted. These persons often become homeless and users of the shelter system.

SCPI funding provided the opportunity and a proposal has been prepared to respond to this need.

The capital budget is still being determined. The annual operating budget is estimated at $430,000.

Overall Philosophy
The vision that is guiding the project is that of the creation of a transitional housing facility where the individual and his/her supports may receive a broad range of effective and appropriate services. This will help them address the range of daily living challenges that they face.

Contacts
Audrey McIlraith
Executive Director
Canadian Paraplegic Association (Manitoba) Inc.
825 Sherbrooke Street
Winnipeg MB R3A 1M5

Phone: (204) 786-4753 ext. 224
Fax (204) 786-1140
e-mail: amcilraith@canparaplegic.org

Case Study #6 : Résidence du Vieux Port - Montreal, Quebec

Physical Description
The Résidence du Vieux Port, opened in 1987, has 40 rooms in Old Montreal. It is operated by the Maison du Père which has been offering shelter and services to homeless men in downtown Montreal for over 30 years.

Major works, at an estimated cost of $11 million, are about to be undertaken in the Maison du Père. This will include increasing the number of shelter beds from 108 to 130, adding 20 studio apartments for men 25 years and over who are ready to live independently with support, and moving the Résidence du Vieux Port. The move of the residence also will permit an increase of capacity to 72 rooms that will be situated on the second and third floors of the building (the studio apartments will be on the fourth floor).

Residents/clients
Homeless men 50 years and over (the oldest is 90) with alcohol and/or mental health problems. Many have been turned away from other residential settings Persons who have mental health problems that make group life difficult, who have very serious health problems or persons who cannot take care of primary needs (e.g. eating, dressing, or severe mobility problems) cannot be housed in the residence.

The men are referred to the Résidence du Vieux Port by the Maison du Père, the Accueil Bonneau, the Centre Dollard-Cormier (addiction treatment), a hospital or a local health and social services centre (CLSC).

Services
Services include meals and snacks, laundry, medical and social support. There are 22 employees as well as 9 volunteers working at the Résidence. Medical services are given by the homelessness team of the local CLSC.

Development History
For years, workers at the Maison du Père had identified the need for long term care and housing for chronically homeless men who had problems with alcohol, drugs and mental health. The Mariner's House in Old Montreal stood empty and in 1987, the International Year of the Homeless, was reopened as the Residence du Vieux Port.

The current decision to merge the Résidence with the Maison du Père is in part propelled by economies of scale for elements such as the laundry, food preparation, and maintenance. The three levels of government will fund the project although $500,000 for equipment (kitchen, laundry) is not covered in the grants. A fund-raising campaign is about to be launched.

The men pay room and board - $450/month for those on social assistance and $470/month for pensioners. This will not change in the new project.

Overall Philosophy
Give long-term support to homeless men 50 years and over who have particular problems – alcoholism, mental health problems, etc.

The project aims to give the men their dignity back, to learn to love themselves, and if desired, to help them reunite with their families.

Concerns and Challenges

- The move of the Résidence du Vieux Port has raised a number of concerns. These include adequate preparation and the impact of the move on the fragile residents.
- There is concern about moving these men back to the downtown area where bars and video lottery machines are ubiquitous as are those who prey on vulnerable persons.
- The co-habitation of the studio apartments and the rooms with the larger shelter and services is currently being defined. These more permanent housing units will be separated from the shelter although dining facilities will be shared. It is proposed to have different shifts to keep the various client groups separate. However, the studios and the Résidence will be sharing a building and at the moment, common access and a shared courtyard are planned. It is still not clear whether measures will be taken to separate these two groups.

Lessons
Working in a team and with partners is absolutely critical to achieve the goals that have been set.

Successes

- Offering long-term housing to vulnerable men.
- Giving men dignity and a supportive community at the end of their lives.

Contacts
Francine Rioux
Assistant administrator
Résidence du Vieux Port
165, place d'Youville
Montréal, H2Y 2B2
Te l: (514) 843-3739
Fax: (514) 843-6964

Geneviève Grégoire
Assistant Director
Maison du Père
550, boul. René-Lévesque est
Montreal, Qc H2L 2L8

Tel : (514) 845-0168
Fax: (514) 845-2108

Case Study #7 : Maison Claire Ménard – Montreal, Quebec

Physical Description
Maison Claire Ménard is located in part of a building complex that houses the Accueil Bonneau, a charitable organisation that has been in operation since 1877. Located in Old Montreal, the Accueil Bonneau offers meals, clothing, counselling, and a day centre. Furthermore it operates rooming houses and supportive housing alone and in partnership with the Maison du Père, another shelter in the downtown area.

Maison Claire Ménard has 31 self-contained units (including one for the janitor).

Residents/clients
The project offers permanent housing to homeless men 50 years and over. Most are referred to by the Accueil Bonneau, Maison du Père or the homelessness team of the local health and social services centre (CLSC).

The men are evaluated for their potential to live independently.

The residence is not adapted for persons with serious mobility problems.

Services
Residents of the Maison Claire Ménard have access to all the services of the Accueil Bonneau (the housing is on the two upper floors of the Accueil Bonneau and connected to the day centre).

Maison Claire Ménard has one social worker and other support is offered by various social services, notably the local CLSC, who offer medical and social services on site a few times a week. The Accueil Bonneau administers medication. The resident janitor handles emergencies and works closely with other team members.

Development History
Forced to rebuild following a gas explosion in 1998, it was decided to renovate upper levels of the building that had contained offices into 31 permanent housing units. Soeur Claire Ménard, one of the workers at the Accueil Bonneau died in the explosion and the housing project was named after her.

The total cost of the renovation of the two residential floors was over $2 million. The project received funding from the Quebec social housing program, AccèsLogis Volet 3, which funds supported housing. Residents pay 25 percent of their income for rent.

Overall Philosophy
As much as possible, the men living in Maison Clare Ménard are supported in independent living. All the residents have leases and all must abide by the internal bylaws. Three residents are represented on the nine-member Board.

Concerns and Challenges
The major challenges are selection of new residents – the need is very high. A second project, Clare Ménard II is currently being planned.

Lessons
- The necessity of working in a team and in partnership with the various service providers.
- Stay focussed on the needs of the individual and their independence.
- Create a pleasant milieu and a community of persons.

Successes
- Getting through all the administrative details to complete the project.
- The renovation of the building, which was in very bad condition, was complex. There was a need to both adapt to the needs of the residents and to respect the architectural constraints placed on the building because it is a heritage building and situated in Old Montreal. Exacting heritage norms were applied to the renovation work.
- The project has increased the independence and stability of the residents – few move out of the project.

Contacts
Soeur Nicole Fournier
Directrice générale

Ronald Vallée
Responsable de l'habitation

Accueil Bonneau Inc.
427, de la Commune est.
Montreal, Qc H2Y 1J4

Tel : (514) 845-6009
Fax : (514) 845-8758

Case Study #8: Birchmount Residence - Toronto, Ontario

Physical Description
Birchmount Residence, situated in south-west Scarborough (the beginning of the suburbs/east Beaches area), is part of Seaton House[7], a multi-faceted shelter for men that has over 500 beds situated in downtown Toronto.

This former 2136 square metre nursing home has 60 beds. The bedrooms vary in size ranging from eight rooms of 11 square metres to four medium sized rooms of up to 18.5 square metres (two men in each room) and six larger ward type rooms of up to 37 square metres with three to five beds in each. Four of the rooms have a washroom attached.

There are five TV rooms (four for smokers), a pool room, two dining rooms (one large), a kitchen for meal preparation, a nursing station, a front office, counselling and administration offices, a clothing room, and storage and maintenance supplies areas in the sub-basement.

Residents/Clients
Birchmount can house men over 50 years (the oldest is 83 years old) and about 60 to 70 are housed annually. Most are in poor health, usually with at least one chronic health problem. Most have some basic hygiene problems and some have mobility problems (about 20 percent use canes or walkers) although they must be able to climb stairs. Some have acute mental and/or physical health problems, cognitive and developmental issues, and about half have a substance abuse problem, usually alcohol. Many are long term shelter users with no family contact or support.

The men must be able to manage personal care with limited staff support, have no incontinence issues, not on oxygen, I.V. or other intrusive medical procedures or equipment. They must be not only willing to be financially responsible and pay the rent but must also behave in a “reliable, predictable and respectful manner in the community”.[8] While they can consume alcohol they must be able to “act appropriately and responsibly” and be willing to co-operate with a harm reduction approach. Neither abuse of medications nor street drugs is allowed.

Services
The services include meals, personal care, housekeeping, counselling, budgeting/finances, nursing, doctors, mental health support, assistance with housing, and some follow-up support in the community. All but mental health services are provided by in-house staff.

---

[7] See Case Study #2 for a description of Seaton House.

[8] Birchmount Residence Admission Criteria

Neighbourhood services available to residents include the Birchmount Bluff's Neighbourhood Centre (Senior's centre and programs, and a swimming pool) Providence Centre Foot Care Clinic, and Centre 55.

Room and board is $701/month for men 65 and over. For men on the Ontario Disability Support Program it is $404/month.

Development History
It was felt that older men were not being assisted and supported appropriately and that the large shelter setting was unsuitable. Because of their age and vulnerability, they were prone to victimisation by younger shelter users. However, while the men were older with deteriorating health, they were not old chronologically nor did they feel they belonged in traditional homes for the aged or long-term care facilities. Distancing them from the larger shelter in a quiet and safe place away from the younger, active and often higher-functioning residents in the hostel was seen as a desirable goal.

The opportunity to realise this came in 1999 when Seaton House was being renovated. A large group of older men were in the shelter system "going nowhere". Many had been living in the older Men's Residence of Seaton House, which continues to this day on the fourth floor.

The residents had to be temporarily moved during the renovations but there was nowhere for this older group to go. The Seaton House team also realized that the older men were the most vulnerable and the least likely to withstand the moving and dislocation associated with a major renovation. It was then decided to find them a more suitable location. An empty nursing home located in the Beaches area of Toronto (a middle and upper middle class area) was identified as potentially a long-term solution by the City of Toronto.

The greatest challenge in the development of Birchmount Residence was the negative reaction of neighbours to the project and the perception of risk to children attending a nearby school. The city set up a community notification process to address concerns and allow for community input. A Community Reference Board, made up of 12-15 residents, service providers, community resource people, councillors and staff was established. Terms of reference and a Community Contract were drawn up. A screening tool for new residents also was developed. This Board continues to meet and has evolved to become more involved in support of programming. Community support also has evolved to include donations to the project including clothing, furniture, books and the establishment of a Volunteer Committee made up of local residents who visit residents, attend picnics and outings.

All eight programs of Seaton House have an annual budget of $18 million, funded by the City of Toronto. Birchmount Residence costs about $1 million a year, minus income from room and board of over $300,000. Home care is covered by

the Community Care Access Centres. Some mental health support work is done by Full Circle, an agency funded by the provincial government.

Overall Philosophy

- Protect, provide for shelter and basic needs.
- Support socially isolated and infirm men with their goals, increasing the options they have for improving their lives.
- Find housing or alternative living arrangements and being able to survive and thrive with greater independence.

Concerns and Challenges
There is need for more supportive housing, more long-term care and homes for the aged that are much more flexible in who they service.

Lessons

- All ages and life situations have the potential to change and grow. Men thrive when given the opportunity for greater independence and growth within a smaller setting than in the large men's downtown shelter.
- The quality of life of the men will only improve with increased interaction with others in a smaller, more humane setting that has few rules and allows for greater interaction with staff. This allows some to gain the confidence and support required to move to more independent living arrangements. Otherwise they will remain in the shelter system and deteriorate with few chances of getting out of the system as time progresses.
- Seaton House as a whole should not be repeated - it is too large.

Successes

- Relationship with the community. Proving to the community that the men were not a threat to them and to have the level of community support that is now being given to Birchmount Residence.
- An average of two residents per month have been moved into supportive or independent housing since the inception of program. A housing worker has established relationships with nursing homes and other housing options for residents who are ready to move (e.g. two units are reserved in a local seniors' housing project in exchange for support that is offered to isolated seniors living in the project).

Contacts
Dan Anstett
Program Supervisor
Birchmount Residence/Long Term Program
Seaton House
339 George St.

Toronto, Ontario
M5A 2N2

Tel: 416-392-5761
Fax: 416-392-5549.
Email: danstet@toronto.ca

Case Study #9: Legion Wing - Prince George, British Columbia

Physical Description
Prince George is a hub for many smaller communities and remote settlements in Northern British Columbia. The Legion Wing is a two-storey apartment building adjacent to a residential care facility and directly above a seniors' centre. Located in a semi-residential neighbourhood with schools and parks, it is two blocks from a shopping mall and has a bus stop at the front door. There are 22 furnished housekeeping rooms (20 square meters) each with a kitchenette and 2-piece bathroom.

Residents/Clients
Residents are "the forgotten pioneers": 75 percent male, 25 percent female; mostly but not all aged 65+; one third with substance abuse problems; one quarter using assistive devices such as canes and walkers; two using oxygen. Their diagnoses include many kinds of cognitive impairment. Residents moved to Legion Wing because they were not capable of self-care due to alcohol or drug dependency and/or cognitive impairment. Some have "lived rough lives in the bush", in shelters or in downtown rooms. (Absolute homelessness is very rare in the north; the climate is too harsh.)

Services
Service providers on-site include a Licensed Practical Nurse (1 FTE), Lifeskills Workers (7 AM to 7 PM, daily), Recreation Worker (weekdays, 6 hours/day) and a Social Worker (.5 FTE), who offer assistance with financial management, homemaking, recreation, and appointments. Visiting service providers include three consistent Home Support workers, Home Nurse, Podiatrist, Physiotherapist, Occupational Therapist, and volunteers who work with the Lifeskills Workers. Residents are served one meal/day -- in the downstairs seniors' centre on weekdays, and in the second floor lounge on weekends. Recreational skills are encouraged. Tenants pay rent based on CMHC guidelines for seniors' subsidized housing. Rent (including room, cable and utilities) plus monthly charges for one meal/day, a program fee, and a pro-rated pharmacy fee, is $506/month.

Development History
In the 1990s, the unmet needs of cyclically homeless, older adults with substance abuse and other health problems who were using temporary shelters and hospital beds became increasingly apparent in the region. This situation spawned the Legion Wing project in 1999. The building, originally intended as seniors' housing, but under-utilised due to its lack of elevator and full private bathrooms, was identified as a potential new home for this client group. The Elderly Services Program, Mental Health, initiated an inter-sectoral group (long-term care, mental health, shelters, elderly outreach services, downtown landlords, anti-poverty groups and Telus Pioneers -- a retiree association), which received annualised funding from a provincial mental health fund. The regional

health authority transferred operations of the Legion Wing to the Elderly Services Program. Changes to the building were minor: two former housekeeping rooms were converted to office, kitchen, and storage space; new windows were installed; wiring was upgraded; furniture and appliances were purchased with funds raised by the Telus Pioneers. The cost of utilities is borne by the regional health authority; administration costs are covered under Mental Health.

The project's philosophy is respectful, client-centred, based on a multi-disciplinary, harm-reduction approach, and its goal is to stabilise and optimise the quality of life for this hard-to-house population.

Concerns and Challenges
Providers are concerned because home support services in British Columbia have been drastically cut, including hygiene support, an important component of care for this particular group. Another concern is that the lack of elevator limits applicants to those who can manage stairs, and exhausts home support workers who carry groceries and supplies upstairs to their clients.

Lessons
- Activities are key. For residents, activities provide stimulation, opportunities for interaction with peers, and alternatives to using alcohol during leisure time. For staff, they provide opportunities to assess clients' functioning.
- Program hours have been altered so that organized activities take place in the evening, a potentially troublesome time for lonely people.
- This "small cluster model" seems to work well – that is, groups of fewer than 25 people together.

Successes
- Several individuals with reputations for public drunkenness have been rehabilitated to become accepted members of the senior community, and some have even been reunited with estranged families.
- Financial abuse of this cognitively impaired, vulnerable population has been averted and reduced.
- Some residents with serious side effects from diabetes have been stabilized.
- The residents have formed a Residents' Association, lobbied for and got a horseshoe pit installed in the city park next to Legion Wing, and held a special event, inviting members of the senior' centre, long-term care residents, local dignitaries and family members, to celebrate its opening.

Contacts
Karla Staff, LTC Assessor, Northern Health, Prince George, BC Telephone (250) 562-1036, Email: Karla.Staff@northernhealth.ca

Louise Holland, RSW, Elderly Services Program, Mental Health Centre, Prince George BC ,Telephone (250) 565-7408, Email: Louise.Holland@northernhealth.ca

Case Study #10: Veterans' Memorial Manor – Vancouver, British Columbia

Physical Description
Veterans' Memorial Manor is located in the Downtown Eastside of Vancouver, British Columbia, the "Skid Row" of Canada, an area familiar to the hard-to-house. The Manor is a five-storey yellow brick building, trimmed in cheerful red, with reception, a community cafeteria, games room, television lounge, offices for service providers, a library and an interior courtyard/garden on the ground level. Upstairs there are 134 units for veterans: 78 bachelor apartments with full bathrooms, 16 units specially designed for persons with disabilities, and 40 bed-sitting rooms with two-piece bathrooms. The units are designed to withstand rough treatment (e.g., floors are linoleum, corners of furniture are rounded). On the roof is a garden with mountain and water views.

Residents/Clients
There are 134 residents (100 percent occupancy), with a turnover rate of approximately 10 percent (that is, 12-13 die each year). They are males, aged 70-94. Applicants must be aged 55+. Most have little formal education and used to work at physical labour, such as logging. Thirty use walkers, 6-7 use scooters, 3-4 use electric wheelchairs, 10-12 use canes (in other words, approximately 40 percent use assistive devices); 18 have been diagnosed with a mental illness and another six are in the early stages of a dementia. The characteristics of residents have changed over the last 17 years: they are older and more frail when they move in now. The main reason for their being there is they were living in very poor conditions, due to poverty, alcohol misuse, and in some cases, undiagnosed Post Traumatic Stress Syndrome. Many had been homeless, "living under the Georgia Viaduct and in the park".

Services
On-site at the Manor are: an administrator, an administrative assistant, a janitor, security personnel 24 x 7, and meal service three times daily in the community cafeteria. Visiting service providers include Counselling, Home Support and Personal Care (on blocked time), Home Nursing daily (with continuity of provider), Occupational and Physical Therapy, Podiatry, haircuts (monthly), doctor's visits (sometimes 3-4 times weekly), assistance with financial management, and palliative care when required. Services provided in the neighbourhood include free bus rides to a day centre. The regional health authority and a non-profit society pay for the off-site services. Rents are $340-$350/month, and include both accommodation and the services listed above. Meals ($2/meal) are subsidized by the federal, provincial and municipal governments. The federal Department of Veterans' Affairs covers Home Support and pharmacy dispensing fees for those veterans who are "too wealthy" (with annual incomes over $16K) to qualify for free services.

Development History
A survey initiated by the Regional Director of the Department of Veterans' Affairs in 1984-85 revealed over 900 veterans living in the downtown core, some "living rough", many in very run down single room occupancy hotels. Survey results prompted the Department of Veterans' Affairs, service clubs (e.g., the Legion), CMHC, the War Amps, and the municipality to work collaboratively in developing Veterans' Memorial Manor. The City of Vancouver leased the land to the project at no cost for 40 years, starting in 1986; and the War Amps furnished 16 units for persons with disabilities and raised funds to pay for an intercom system. Veterans' Manor opened in 1986. The philosophy underlying the project is to "provide safe, clean accommodation and good food for vets at low cost". And, "if they want to die here, we let them die here".

Capital expenses were $4.3M, provided by CMHC through the Non-Profit housing program, the Department of Veterans' Affairs and the City of Vancouver. The actual annual operating budget is not known, but includes $221K for salaries, $25K for property taxes, and $14K for building insurance. Annual revenue sources include $80K for overhead expenses from CMHC, rental income from the veterans' units, and rental of the community cafeteria to the City of Vancouver for $55K+. The services not covered in the annual operating budget are all those services provided through the health authority's long-term care program, and those provided by a non-profit society in the region.

Concerns and Challenges
There are no major concerns, according to the administrator, who believes that local veterans' needs are being well met.

Lessons
Advice was offered to those who may want to create a similar housing option for this hard-to-house population: "Be big, have a good sense of humour, be easy going" and be a veteran. Other advice is not to open projects to younger homeless people, even if occupancy is not 100 percent - they may prey on the older, more frail residents.

Successes
- The project "took the worst of the worst" and "took the guys off the streets!"
- The Veterans' Memorial Manor benefits the poorest veterans by providing safe, secure shelter, access to inexpensive meals, medical and nursing care on a regular basis, and a home in a familiar neighbourhood.
- The project benefits taxpayers by keeping ill and dying veterans out of emergency or palliative care in hospitals, saving millions of dollars per year.
- Several residents stopped misusing alcohol once they were housed and cared for at Veterans' Memorial Manor, and moved into regular social housing for seniors.

Contacts
Warren Matheson, Administrator, 310 Alexander Street, Vancouver BC V6A 1C3. Telephone (604) 688-4560, Fax (604) 688-1427.

Jack Macleod, Administrative Assistant, Same address and numbers as above.

Case Study #11: Former Integrated Program, Oak Bay Lodge – Victoria, British Columbia

Physical Description

Oak Bay Lodge, formerly a hotel, is located on the border of an upscale residential area in Victoria. A four-storey structure with a grand entrance and large lounge, it has all the features typical of a 1970s residential care facility. It has had numerous major renovations over the years, responding to the changing resident profile. On the same property are supportive housing and an adult day centre.

Residents/Clients

There are 282 beds in the Lodge. All Lodge residents require complex care; most are frail, elderly females aged 85+ who have multiple diagnoses, including a cognitive impairment. In 1989, an "integrated program" was launched: three beds in the facility were dedicated for use by the clients of VISTA (an outreach program in Victoria that serves older adults who have problems with alcohol abuse and other addictions). A few of the program clients live in rough conditions and are cyclically homeless due to behaviours associated with heavy drinking, isolation and lack of both social and domestic skills. Some are permanently cognitively impaired, lacking judgement and awareness of the impact of their behaviours on others; they swing from crisis to intervention to crisis, at considerable cost to both the taxpayer and their own physical and mental health. They appear very much older than their age.

Services

The Lodge offers 24-hour nursing care, meals on-site, and all the other supports typical of residential long-term care. They do not provide a de-toxification program. No extra services were added for the clients of the VISTA program.

Development History

In 1989, VISTA providers approached Oak Bay Lodge, requesting dedicated beds for their clients, some of whom were being discharged from hospital with no place to go, others on the edge of homelessness due to their behaviours. These clients needed structure, rest, nourishment, and attention to chronic and progressive disorders – in short, to be rehabilitated. The facility agreed to dedicate three beds to this program, which started the same year. During the first year, a part-time (.75 FTE) VISTA counsellor, with an office at the Lodge, assumed numerous duties, including developing policies related to VISTA residents, providing in-service education to front line staff, connecting with the community, monitoring clients' progress and discharge planning. After one year, these duties were assumed by VISTA outreach counsellors, whose offices were also on site. The program continued for 12 years, but was cancelled in 2002 for

numerous reasons. 1) Caseload pressures increased in the facility, allowing less flexibility of time for front line staff. 2) There were changes in both management and front line staff, which resulted in changes in the residential culture. 3) Caseloads increased for VISTA workers, allowing them less time with clients living at the facility. 4) Increased accessibility of inpatient psychogeriatric care in the region – including detoxification and interdisciplinary interventions - made this residential treatment program less necessary. 5) VISTA offices were moved elsewhere.

Concerns and Challenges

Managers and front line workers at VISTA continue to be concerned about the fate of older adults who have addictions (primarily alcohol), few social skills and networks, limited or no domestic skills, and who are often isolated and vulnerable to abuse. One of the bright lights for VISTA is that a specially designed project for their client group is now being built in the Greater Victoria area. It is called Fairway Woods. (See Case Study #12.)

Lessons

The most important lessons learned from the integrated program were these:

- Education/training (e.g., on the characteristics of frontal lobe dementia) should be funded for front line caregivers in a residential care facility where an "integrated program" is introduced. Staff members need orientation in the social model of care and special knowledge that will help them understand clients whose behaviours can be challenging.
- Context makes a difference. In this climate of very limited residential care beds, and under-funded staffing in facilities, facilities naturally prefer to accept residents who are not already known to be "difficult".
- To re-create a successful integrated program, it would be necessary to have a part- or full-time program worker on-site at the residence, the "orchestra leader" of a special team.
- VISTA workers say that there is no single "correct" approach to providing care to elderly and/or chronically ill homeless or hard-to-house persons. Two possibilities are: 1) a well-supported, integrated program, in a designated area of a residential care facility for clients who need complex care; and 2) separate, supportive housing options that are purpose-designed and staffed, for those who need supervision and support (but not nursing care).

Successes

The most outstanding successes are the lives saved thanks to this program, the many lessons learned from the experience, and the fact that it has drawn attention to the needs of older adults with addictions problems who are at risk of homelessness in the greater Victoria area.

Contacts

Anne Wood, RSW, MSW, Counsellor, VISTA (Victoria Innovative Seniors Treatment Approach), Victoria BC.
Telephone (250) 953-3966, Fax (250) 356-9342
Email: Anne.Wood@caphealth.org

Joyce Westcott, Administrator, Oak Bay Lodge, Victoria BC.
Telephone (250) 370-6600, Fax (250) 370-6601
Email: joyce.westcott@gems9.gov.bc.ca

Case Study #12: Fairway Woods -- Victoria, British Columbia

Physical Description
Fairway Woods is a four-storey building being purpose-built in a suburban semi-residential area, on the same property as an extended care home, a dementia care home and a day centre for seniors – property owned by the regional health authority. This site is close to public transit, doctors' offices/medical services and retail outlets. Fairway Woods will have 32 self-contained 46-51 square meter, one-bedroom apartments (of which eight will be designed for persons with disabilities) in groups of eight per floor, activity areas on each floor, communal dining room, a generous outdoor patio surrounded by trees, and a protected front porch. The height and profile of the building is similar to a private condominium project across the street, so it blends in with the neighbourhood. The entire building is designed for ageing in place.

Residents/Clients
Residents will be seniors (aged 55+), likely more males than females, currently living in all regions of the Greater Victoria area, who have multiple health problems, such as mental illness, addictions, poor nutrition, and physical ailments. In addition, many of them lack self-care skills and social supports and have been chronically homeless or have lived in substandard downtown hotels. Some have had difficulty "fitting in", in mainstream seniors' housing.

Services
There will be a Lifeskills Worker on the premises 24 x 7, assisting with activities such as budgeting, cooking, self-care, appointments, shopping; and a (1 FTE) Co-ordinator, who will be on site during regular business hours. One meal per day will be provided in the large dining room on the main floor. Tenants will have the option of cooking other meals in their apartments either by themselves or with assistance. Like other elderly people with health problems who live in their own homes, tenants will be eligible for Home Support, Home Nursing, and other services provided through the regional health authority, such as counsellors for people who have problems with addictions.

Development History
The development of this project began in early 1997, when four agencies collaborated to envision a supportive housing project for older adults who are homeless or hard-to-house. The four agencies were VISTA (Victoria Innovative Seniors' Agency, as it was called then, an outreach program for older adults with alcohol addiction and related problems), Cool Aid (the Victoria Cool Aid Society, a provider of emergency shelter, low cost housing, and other supports for homeless and hard-to-house persons in the Victoria area), the Regional District Health Facilities Planning department, and the Capital Region Health Authority (now called Vancouver Island Health Authority). Months of preparation and efforts to seek firm commitment from all agencies preceded the preparation of the proposal, approved by BC Housing under their Hard-to-House funding stream in

2000. There is now an operating agreement in place between BC Housing and Cool Aid, which restricts the use of the building to supportive seniors' housing for 60 years. The regional health authority, owner of the land, has leased the property to the project, for $1/year for 60 years. Construction of the dedicated facility is almost complete. (Information on capital costs is not available.) The annual operating budget is $650,000, with the regional health authority providing $350K/year, BC Housing providing $175,000 and $125,000 income from rent.

An outreach worker with Cool Aid is a key participant in preparing for the opening of the facility; she is a link between "the street" and Fairway Woods, and a member of the Screening Committee for tenant selection. The opening is planned for June, 2003.

Concerns and Challenges
Despite the development of this housing option for homeless and hard-to-house seniors in the Victoria region, there is still an unmet need for highly subsidized housing and assistance with financial management, within this population.

Lessons
- It can take a very long time, from concept to construction, to meet the needs of homeless and hard-to-house people. Non-profit groups considering a project similar to Fairway Woods should prepare for several years in planning and preparation.
- Creating this housing option has raised awareness and understanding of this population at both regional and provincial decision-making levels.

Successes
It is anticipated that there will be many successes resulting from this project:
- Clients' quality of life will increase.
- Services such as Home Support, Home Nursing and Mental Health support will be delivered more efficiently, when these clients are under one roof.
- The health care system will benefit from a reduction in inappropriate use of hospital and residential care beds, police time, and outreach service time.

Contacts
John Crean, Housing Manager, Victoria Cool Aid Society, Telephone (250) 383-1977, Fax (250) 383-1639, Email: jcrean@coolaid.org

Dennis Suwala, Manager, Special Needs Housing, Vancouver Island Health Authority, South Island Region, Telephone (250) 370-5697, Fax. (250) 370-5676, Email: Dennis.Suwala@caphealth.org

Case Study #13: Pioneer Inn – Whitehorse, Yukon

Physical Description
Whitehorse, a city of approximately 21,000, is the hub of Yukon. The Pioneer Inn is located three blocks from the main street in Whitehorse, close to shops and services. The hotel has 30 rooms, of which up to 18 are utilized for long-term tenancy of older adults who are homeless or hard-to-house. All rooms have a full bathroom and furniture; 12 have an eat-in kitchenette (i.e., they are essentially small bachelor apartments of approximately 19 square meters.

Residents/Clients
There is capacity for 18 long-term tenants who need assistance with everyday life. Occupancy at time of writing was 100 percent. Tenants are mostly male, "because females have more resources" such as a transition house, and because there are proportionately more males in the north in all age groups, compared to the rest of Canada. Current tenants range in age from 45-73, and have multiple health problems, including arthritis, heart condition, diabetes, and cardiovascular disease. Some "are just old; they've lived in the bush so long that everything hurts". More than half of these tenants have problems related to alcohol addiction. Five use assistive devices (e.g., walkers). The tenants' health profile has worsened in recent years since the hotel manager started "taking in street guys". The main reason they are living at the Pioneer Inn under the care of the manager is that "Nobody else will take them!". There is very little turnover -- they settle in.

Services
Weekly housekeeping services (cleaning and laundry) are provided by the hotel. The hotel manager and her family provide other services, including daily checks of the rooms, free coffee in the lounge, free laundry soap, reminders regarding medications, escort to appointments including hospital emergency, grocery shopping, help with reading mail and prescriptions, and three meals/week cooked at the manager's home and delivered to the tenants who want them. The grateful sibling of a deceased tenant provides one more meal per week. Nearby resources include a Salvation Army community kitchen, accessible to "the guys who can get there", and a Golden Age Society centre, where "they don't fit in". The tenants' rent ($600/month) is paid directly to the hotel owner by Yukon Health and Social Services.

Another service is an Outreach Team, in a van, with a nurse and outreach worker, who visit twice weekly, to provide social interaction and health checks. This service, while highly valued by both clients and providers, will be cut in June 2003.

Development History
Approximately 18 years ago, the hotel manager recognized the common sense of renting out under-utilized hotel rooms in Yukon during low season (November to

May) to local people who could otherwise perish in their cabins, trailers or the street during the severe winters. The idea was win-win: it would provide cash flow for the hotel during winter months, and provide a much-needed resource in the north. The owner of the Pioneer Inn co-operated in this venture. The service simply grew, as the homeless and hard-to-house population grew, and as the proportion of older people needing subsidized housing continued to exceed available resources in Yukon.

Concerns and Challenges
One concern is that several of the tenants have predatory "friends" who financially abuse them – the tenants must be protected, while their adulthood and privacy are simultaneously respected. A social concern is that there are few resources for hard-to-house people in Yukon, especially "guys who have been out in the bush for years" … "who are not well-dressed, not well mannered, could be self-sufficient with some supervision"…and who "are desperately lonely".

Lessons
- "Everyone needs to be needed."
- Advice: "Ask the person needing help to help you, so that they have a sense of worth, the satisfaction of being needed. Make the relationship reciprocal."
- Relationship-building with this population is key to success; trust takes time to build. This means that continuity, commitment and longevity of service providers must be one of the basics of any program designed for this group.
- "Every person, no matter who they are, deserves respect, a decent place to live, and care. No matter who."

Successes
- A caring micro-neighbourhood or extended family has been created: the tenants watch out for the manager's welfare, help out around the hotel (e.g., sweeping the parking lot) and have learned to look out for each other.
- Another facet of success is that taxpayers have been saved innumerable expenses in hospital emergency, long-term care, policing, and other services required by those who end up living and dying in the streets.

Contacts
Adeline MacDonald, General Manager, Pioneer Inn, 2141 Second Avenue, Whitehorse, Yukon Y1A 1C5, Telephone (867) 668-2828, Fax. (867) 668-2848, Email: atomsoul@hotmail.com

Kip Veale, Seniors' Liaison, Health and Social Services, Yukon, Telephone (867) 667-3070, Fax (867) 667-5819, Email: catherine.veale@gov.yk.ca

APPENDIX F: CASE STUDY QUESTIONS

A: Description of the Project (Program or Strategy)

A1) What is the location? *(Please describe the neighbourhood.)*

A2) Why there?

A3) What is the scale of the project – how big is it and what components does it include? *(E.g., components might include private rooms, common areas, dining room, office for visiting service providers.)*

A4) If there are dwelling units, what are they like? *(Please describe, e.g., "200 square foot furnished rooms, each with a lockable door, large window, two-piece bathroom".)*

A5) What services are provided? *(Examples could be personal care, housekeeping, counselling, one meal per day.)*

A6) Which of these are provided by on-site staff? What staff do you have on-site. *(E.g., nurses, care aides, activation workers, housekeepers, counsellors.)*

A7) Which services are provided by visiting providers?

A8) Which services are available/accessed at a nearby resource? *(E.g., a nearby community centre or seniors' centre.)*

A9) Who provides the services? *(Please be generic. No proper names, acronyms or initials please.)*

A10) Do tenants pay for a portion of their rent and services?

B: Development History

B1) What needs were identified before this project got started?

B2) When were the needs identified?

B3) By whom? *(Please be generic, e.g., "health authority hired a consultant to do needs assessment". No personal names, initials or acronyms please.)*

B4) What partners were involved in the development of this project? *(Please be generic; no proper names, initials or acronyms, please.)*

B5) How much did/does/will it cost for capital? *(E.g., for land and construction or renovation.)* Where did/does/will this money come from?

B6) What is the annual operating budget? Where does the money come from for operations?

B7) What services does this sum not cover? *(E.g., home care services delivered on site by regional health authority.)* Who funds these other services?

B8) What is the overall philosophy of this project?

C: Description of Clients or Residents

C1) How many residents/clients do you serve in this project at one time?

C2) How many per year?

C3) What is their gender and age range?

C4) What is their health profile? *(E.g., diagnoses, mobility, ability to do personal care, cognitive functioning.)*

C5) Has the health profile of the typical client/resident changed within the last 10 years? In what ways?

C6) How many use assistive devices? *(E.g., cane, walker.)*

C7) What is the main reason for their being with you?

D: Some Reflection

D1) What have been the most difficult challenges of this project?

D2) What are the unmet needs that still exist for this client group in your community?

D3) What have been the most outstanding successes of this project?

D4) Who benefits from this project? How?

D5) Why does this matter?

D6) What are the most important lessons you learned from doing this project? *(E.g., if someone from another province or territory wanted to imitate your project in their own region, what advice would you give them?)*

E: Contact Information

E1) Please provide the full name, title, mailing address, telephone and fax numbers and email address for two key contacts for this project.

THANK YOU VERY MUCH FOR YOUR TIME AND INPUT!

Visit our home page at www.cmhc-schl.gc.ca