Sage Seniors Association

CREATING SAFER SPACES:

A Resource for Domestic Violence Shelters Supporting Older Women

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SECTION I

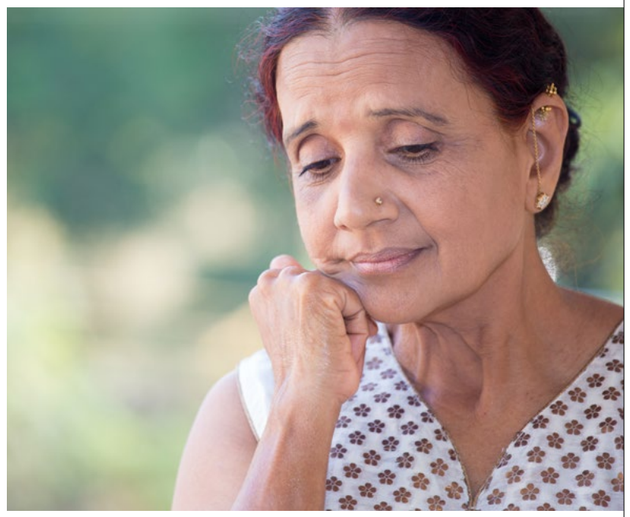
UNDERSTANDING THE NEEDS OF OLDER ADULTS

1. INTRODUCTION

From 2012-2015, domestic and family violence shelter stakeholders from across Canada worked to address the gap in existing shelter service for older women: the result was Promising Practices Across Canada For Housing Women Who Are Older And Fleeing Abuse, a resource for shelters to consider how they might adapt programs to be more responsive and inclusive of women who are older.

Older adults have been disproportionately impacted by the isolation caused by the COVID-19 pandemic, which increased their vulnerability to abuse and enabled abuse to happen unchecked. This has resulted in an increasing number of older women seeking shelter from abuse. In order to respond to the need, domestic violence shelters must adapt to accommodate older women appropriately.

In 2021, Sage Seniors Association received funding to undertake a project to help Edmonton-area shelters respond to the unique needs of the increasing number of older women seeking shelter from abuse. The purpose of this project was to build on the recommendations of the Promising Practices report and develop materials and resources for emergency shelters to better support older women.



The project team completed an environmental scan of the older adult-related resources that are currently available for domestic and family violence shelters, reviewed information and literature related to the impact of COVID-19 on elder abuse, and consulted with Edmonton-area shelters regarding their experience and need when serving older adults.

With this resource, we hope to help domestic and family violence shelters respond to the unique needs of the increasing number of older women seeking shelter from abuse.

PROMISING PRACTICES

1. Nurture an environment that values women who are older
2. Develop outreach strategies tailored to women who are older
3. Provide individualized, woman-centred support for women who are older
4. Focus on relationships and relationship building for women who are older
5. Focus on safety for women who are older
6. Facilitate access to healthcare for women who are older
7. Develop strategic partnerships to help women who are older get the services they want and need
8. Provide women who are older with more time to transition
9. Support women who are older after they leave the transition house
10. Integrate evaluation into practice, including documentation of services used by older women
11. Work towards system change for women who are older

This resource book was made possible by funding from Women's Shelters Canada (COVID-19 Response & Recovery Funding for VAW Shelters and Transition Houses).

SAGE SENIORS ASSOCIATION

Sage is a multi-service senior-serving organization providing a comprehensive spectrum of supports and services to seniors in the greater Edmonton area and beyond. Our approach is fundamentally relational in nature, and we employ a strengths-based practice that seeks to increase resilience and reduce vulnerability in seniors when needed, and to inspire them to keep engaging with, building, and enriching our communities. We work to protect and promote healthy aging in community, reduce the risk of social isolation, improve quality of life, and positively impact the physical, emotional, and psychological wellbeing of seniors.

At Sage, we believe that all of us - regardless of age - have strengths, abilities, and gifts to share. We also know that everyone experiences vulnerability in different times and different ways as we transition through life. Through our programs and services, we work with seniors to meet both of these equally important aspects of aging: increasing resilience and reducing vulnerability when needed, and inspiring seniors to continue to build and enrich our communities.

Our vision of a community where all seniors are valued and have the opportunity to live according to their beliefs, abilities, and aspirations underwrites our approach and practice throughout the organization: we have a deep understanding of the diversity of the seniors population and work actively to create welcoming spaces, reach out to marginalized, equity-seeking, and vulnerable populations, and actively engage in anti-racist and anti-oppressive practices in all of our work.

SENIORS SAFE HOUSE

As part of our work, Sage operates a Seniors Safe House, which provides temporary accommodation for men and women 60 years of age and older who are in need of refuge after leaving an abusive situation. Qualified social work staff provide the holistic case management, peer support, professional and practical assistance, and connections to community resources that help residents deal with all the areas of their lives that have been impacted by abuse. Safe House staff and residents are fully supported by Sage's broader programming, including life enrichment activities and social work supports.

WHY A SAFE HOUSE FOR SENIORS?

The needs of older adults are different from those of younger women: older adults often have mobility or complex health needs that require unique supports that the Seniors Safe house can help with.

Elder abuse also differs from domestic violence in that it can include emotional abuse, financial abuse, neglect, and medication abuse as well as physical and sexual abuse – often more than one type of abuse is occurring simultaneously. Persistent ageism also enables elder abuse to go unrecognized and the consequences to be overlooked.

Seniors experiencing abuse often have unresolved health issues to address and need to be connected to medical resources, including nursing support, Community Geriatric Psychiatry, Home Living supports, and other specialists. When financial abuse has occurred, seniors will need help securing bank accounts and making changes to relevant information required by pension and benefits administrators.

Seniors can also require more time at the shelter before they are able to transition into community. The need for affordable, accessible housing or assisted living, unstable health issues, and stabilized income supports can lengthen the stay.

Sage's Seniors Safe House remains the only service of its kind in Northern Alberta.

WHAT WE HEARD

In 2023, Sage consulted with domestic and family violence shelters in the greater Edmonton area to better understand the challenges they face when meeting the needs of older adults, and to determine the tools and/or resources that would best increase their capacity to support older adults seeking shelter from abuse. This is what we heard.

Older women and shelter use:

- Most shelters have seen an increase in the number of older women accessing their services over the last several years.
- In the post-COVID period, there has been an increase in the severity of the abuse that has been experienced by their clients, including increased physical harm and destruction of property. Shelters are also seeing an increase in mental health issues and substance abuse.
- The older women they serve are often experiencing financial abuse, typically involving adult children, and setting boundaries with them can be difficult.
- Older women are often experiencing grief and missing their grandchildren while they are in the shelter. Relationship-building tends to be particularly important for these clients, but outside of goal-setting, it currently tends to be done informally.

> "How do you fill their time while they're in the shelter. You know that they're missing their family and their grandchildren and their great-grandchildren. How do we offer purpose?

Accessibility:

- The shelters use a communal living model with private or semi-private bedrooms that are located on a different floor from the main living area.
- Bedrooms tend to be deemed “accessible” because they are on the main floor and don’t involve stairs. If there is an accessible bedroom, there is likely to only be one.
- Changes regarding accessibility are made slowly when funding is secured on a project-by-project basis.

Approach to service delivery:

- All of the shelters are working in partnership with other community organizations (e.g. YWCA), government services (e.g. Income Support); healthcare (e.g. hospitals); mental health professionals (e.g. psychologists), and police to provide support where and how it’s needed.
- The shelters apply a trauma-informed, harm-reduction approach in their work: because the shelters are person-centred, they identify needs and do their best to accommodate them.

Inclusion:

- Shelters offer culturally and/or spiritually relevant programs, opportunities, and/or space to meet the needs of a diverse clientele.
- If language is a barrier, most shelters rely on tools like CanTalk to navigate the situation, but access translators when possible.
- Clients need to be independent while in the shelters, but home care may be arranged if needed.

Needs:

- The average stay is three to four weeks, but clients often need to stay much longer while they wait to secure financial supports or access appropriate housing.
- Some older women struggle with the technology and online systems that are now used to access services, and this requires additional time and support.
- Shelter staff identified a need to better understand seniors’ services and benefits, including the restrictions related to homecare and financial supports.

> “We sit down with them and say, “What do you need from us? We’ll work with the goals that you identify - with you.”

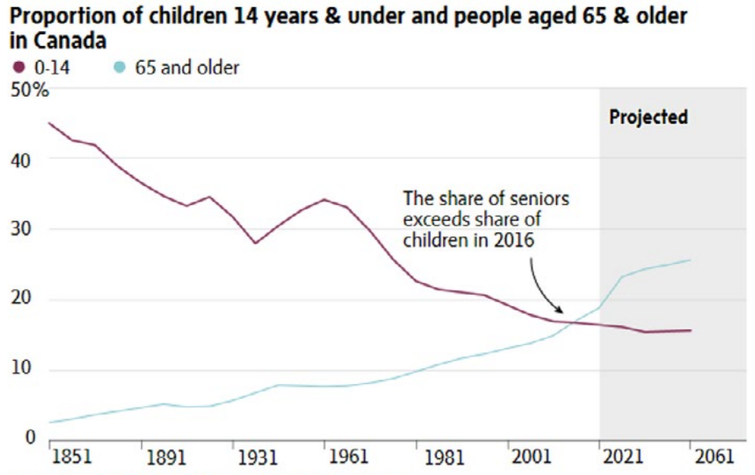
SENIORS’ DEMOGRAPHIC

Whether we are referring to ‘older adults’ or ‘seniors’, we are talking about a wide variety of age, income, ability, origin, and other traditional demographic markers. It is important to remember that seniors have diverse experiences and backgrounds, living arrangements, strengths and aspirations, support systems, levels of education, needs, and desires.

The Government of Alberta (2020) reports that every month, approximately 4,000 Albertans turn 65, and more than one million individuals in Alberta will be over the age of 65 by 2035. By the year 2040, seniors will account for 18% of the Alberta population, and more than half (54%) of seniors will be over 75 years of age (Office of Statistics and Information - Demography and Social Statistics, 2019). The number of people aged 80 and older is also projected to increase from 3% to 5% (Government of Alberta, 2019).

The number of immigrants and visible minorities within this population is also significant: immigrants currently comprise 30% of people aged 65-74, and 10% of that age group are visible minorities. Among people aged 75 and older, 30% are immigrants, and roughly 8% are visible minorities (AFE, 2015). People whose first language is neither English nor French are projected to comprise almost one-third of the total population by 2031 (MacRae-Krisa and Paetsch, 2013).

Poverty in seniors almost tripled between 1995 and 2013 (from 3.9% to 11.1%), and close to 30% of single senior women are living in poverty (Shillington, 2016). These numbers are not expected to decrease. Only 15-20% of middle-income Canadians have saved enough for retirement, and despite new trends toward working past the age of 65, a significant percentage of Canadians will face a substantial drop in their living standard after retirement (Shillington, 2016).



Source: The Globe and Mail; STATSCAN, 2016 Census

A NOTE ON LANGUAGE

Ageism (see page 10) is a key barrier to participation for seniors that can significantly impact quality of life. It can lead to the isolation, invisibility, and social exclusion of older adults. It can also be a cause for individual acts of age discrimination and can lead to elder abuse. It can have a negative impact on the mental and physical health of older adults and increase their vulnerability.

A further challenge with ageism is that people of all ages can hold ageist beliefs, including seniors themselves. This internalized ageism (see page 11) can be a critical barrier to access: when older adults reject the idea that they are 'seniors', they may be less likely to access the resources, support, and opportunities available to them because of their age.

Ageism is a way of thinking and making assumptions about older people based on negative attitudes and stereotypes about aging, and that can include the language that we use. For this reason, we use the words 'senior' and 'older adult' and 'older women' interchangeably in this resource guide.

We would also like to acknowledge that the term 'Elder' is a specific designation in Indigenous communities that has a different meaning from the way it is used in the term 'elder abuse'. We use the term 'elder abuse' throughout this resource guide because that is the term recognized by the World Health Organization, the Government of Canada, and the Government of Alberta.

> "I'm confident in saying that we do notice a lot more people at the shelter who are 55 years of age or older...I can't give you a percentage, but I would say it's been steadily increasing, you know, from my experience, and I've been in the field for over 15 years, close to maybe 18.

THE IMPACT OF COVID-19

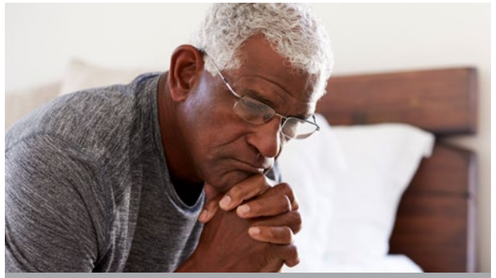
On March 11, 2020, when the World Health Organization declared a global pandemic, older adults were immediately identified as being particularly at risk (Cucinotta and Vanelli, 2020). Duration of quarantine, fear of infection, frustration and boredom, inadequate supplies, and inadequate information have all since been identified as stressors that may have long-term impacts on mental and physical health.

Unsurprisingly, length of isolation was a critical factor: the longer the period of quarantine or isolation, the greater the impact on mental health in particular (Brooks et al., 2020). For older adults facing extended periods of time alone, the COVID-19 pandemic brought the consequences of social isolation into sharp focus.

In July 2020, Statistics Canada released a briefing document on the vulnerability of Canadians living with disabilities during the pandemic, including older adults (aged 60+) who comprise one-third of that population: key concerns included the impact of isolation on general wellbeing, compromised access to help with the activities of daily living, and lack of access to the technology (i.e. internet) that was such a mainstay for knowledge mobilization and social connection through the pandemic (Statistics Canada, 2020).

We are still learning about the long-term impacts of COVID-19 on seniors, but must acknowledge that the people we are working with today may have been disproportionately impacted by the pandemic, and still dealing with its affects on their physical, emotional, and mental wellbeing.

> As the pandemic continued throughout the summer and fall of 2020, there were ongoing concerns of increased social isolation, elder abuse, worsened mental health, and continued challenges in meeting basic needs. Seniors living in intergenerational households were at increased risk of contracting the virus and caregiver burnout and staff shortages were also identified as contributing to, and exacerbating, these risk factors."
>
> *– (ESPC, April 2021)*



> They find loneliness is a big thing that comes up for them. Probably more likely to be abused by family members or their children. Memory. Memory is a big thing. It's harder to find services, especially housing. Finances. I mean, that's typical all across but certainly when you're in your 60s and older, it just seems to be more barriers in helping them move forward. In the few we've had, there's been long term health issues.

2. WHAT IS AGEISM?

In 2017, the Government of Alberta agreed to include age as a discriminating factor under the Alberta Human Rights Act.

Aging is a highly individual experience, and it is not possible to generalize about the skills and abilities of an older person based on age, any more than it is possible to make assumptions about someone based on any other aspect of their identity. But our society tends to value youth over age, and as an adult becomes older, they are likely to experience discrimination and barriers related to the way our society views aging.

The term ageism refers to two separate but connected ideas. It is both:

- A way of thinking and making assumptions about older people based on negative attitudes and stereotypes about aging, and;
- A tendency to structure society based on the assumption that everyone is 'young' and failing to consider the needs of older people.

Stereotypes tend to focus on seniors as either frail, senile, and dependent, or active, healthy, and independent. On the one hand, the image of the frail senior feeds negative stereotypes about aging, and on the other, the independent senior is positioned as having successfully aged because of their personal discipline and choices: there is no middle ground, and no room for the complex realities of lived experience (Frameworks Institute).

Ageism can also be more structural in nature - for example, when services and facilities are designed with the assumption that everyone is 'young' (OHRC). A transit plan that significantly increases distances between bus stops, for example, is a structural form of ageism that dismisses the diminished mobility and increased impact of falling experienced by many older adults.

Ageism is a key barrier to participation for seniors, and can significantly impact quality of life. It can lead to the isolation, invisibility, and social exclusion of older adults. It can be a cause for individual acts of age discrimination, and can lead to elder abuse.

Elder abuse is defined as any action or inaction by a person in a trusting relationship that jeopardizes the health or wellbeing of an older adult. It includes denial of an older adult's fundamental rights, and neglect (active or passive) by a caregiver. It can take many forms including: financial, physical, emotional, sexual, and psychological abuse or neglect. There is reason to believe that ageism is associated with an increase in elder abuse in our society (CNPEA, 2022).

Ageism can also result in the warning signs of elder abuse being overlooked or dismissed. For example, in situations of abuse, seniors may not be taken seriously because they are viewed as being confused or forgetful, and seen as complainers. For more information on elder abuse, see pages 30-31.

"Unlike other forms of discrimination, including sexism and racism, ageism is socially acceptable, strongly institutionalised, largely undetected and unchallenged."

– (WHO, 2016)

The term 'gendered ageism' has been coined to cover the intersection of age and gender, and it refers to differences in ageism faced by women compared with men...Women are often in a situation of double jeopardy in which patriarchal norms and a preoccupation with youth result in a faster deterioration of older women's status compared with that of men.

– Global Report on Ageism, WHO 2021

INTERNALIZED AGEISM

A further challenge in combatting ageism is that people of all ages can hold ageist beliefs, including seniors themselves. This internalized ageism can be a barrier to access: when older adults reject the idea that they are 'seniors', they may be less likely to access the resources, support, and opportunities available to them because of their age.

Internalized ageism is often rooted in a fear of growing older that is associated with frailty, mortality, and the marginalization that results from ageism. Because ageist stereotypes tend to categorize individuals into overly simplistic and harmful generalizations (e.g. healthy or frail, vulnerable or resilient), internalized ageism results in seniors fearing or pushing back against all aspects of aging, both positive and negative. This false dichotomy fails to recognize the richness of the experience and the duality that often exists within individuals.

Internalized ageism refers to the extent to which older adults take on the social norms that devalue or marginalize older persons. They may do this at an individual level by acting in ways that reinforces the youth norm – battling the obvious and visible markers of aging such as grey hair or wrinkles. Internalized ageism may also be manifested by denial of any commonality with others in a cohort, such as the familiar objection of an eighty-five-year-old woman or man who vehemently does not want to be associated with 'all those old people'.

– Ageism: Concepts and Theories, Law Commission of Ontario

UNCONSCIOUS BIAS

When individuals accept ageist beliefs and stereotypes as inevitable facts of aging and becoming older, this contributes to implicit ageism or unconscious bias. Unconscious biases can have a negative influence on the feelings and behaviours of individuals towards persons of different ages in ways that they are unaware of (World Health Organization, 2021), and can hamper the quality of services provided for older adults. When we are aware of our own beliefs about the aging process, we can reframe our interactions with older adults in a more positive context.

Use the questions in THINKING ABOUT AGEISM (pages 13-14) to think about and challenge the ageist beliefs and stereotypes you may have.

THINKING ABOUT AGEISM		
1. How concerned are you about getting older? NOT AT ALL A LITTLE VERY		
Explain:		
2. How would you describe your understanding of the changes that occur as we age? NO UNDERSTANDING SOME UNDERSTANDING STRONG UNDERSTANDING		
Explain:		
3. **TRUE OR FALSE**	**T**	**F**
a. The majority of seniors (65+) have Alzheimer's Disease		
b. The five senses (sight, hearing, taste, touch, smell) all tend to decline as we age		
c. Most older adults lose interest in and capacity for sexual relations		
d. Older adults have more trouble sleeping that younger adults do		
e. Clinical depression occurs more frequently in older people than younger people		
f. Physical strength tends to decline with age		
g. Older workers cannot work as effectively as younger workers		
h. Older adults take longer to recover from physical and psychological stress		
i. Older people do not adapt as well as younger people when they relocate to a new environment		
j. Memory loss is a normal part of aging		
k. Alcoholism and alcohol abuse are significantly greater problems for those over the age of 65 than those under 65		
l. Personality changes with age		
m. As people grow older, they face fewer acute health conditions and more chronic health conditions		
n. It is very difficult for older adults to learn new things		

*** *For answers see page 54*

4. NEVER – SOMETIMES - OFTEN	N	S	O
I compliment seniors on how good they look for their age.			
I tell older adults jokes about old age.			
I have told an older adult, “You’re too old for that!”			
When I find out someone’s age, I may say, “You don’t look that old.”			
When a senior has an ailment, I may say, “That’s normal at your age.”			
When an older adult can’t remember something, I might say, “That’s what they call a ‘Senior Moment’.”			
I talk louder or slower to older adults because of their age.			
I try to use simple words when talking to seniors.			
I will ignore or avoid seniors because of their age.			
When a slow driver is in front of me, I may think, “It must be an old person.”			
I have called older women “young lady.”			

5. Do you think you hold stereotypes about older adults?

6. Do you think you have engaged in behaviour that could be considered ageist?

7. Do you recall witnessing ageist behaviour in others?

These questions are excerpted from Age Friendly Edmonton’s online **Respect and Inclusion Workshop.**

3. UNDERSTANDING OLDER ADULTS

“People who have faced homelessness age more quickly than the general population. In general, homeless people are said to be physiologically old at around age 50... This means that they have lost the ability or potential capacity to perform daily activities and tasks that can be normally expected of others, be it biological, psychological or social.”

– Older Adult Council of Calgary, Older Adults and Homelessness (2018)

LIFE COURSE APPROACH AND THE SOCIAL DETERMINANTS OF HEALTH

The life course perspective takes a broad account of a person’s life and chronological history to understand the person that they are today (Hutchison, 2011). Our lives and behaviours are shaped by both personal and societal events. Many individuals will experience personal milestones, such as graduating from high school, getting married, or becoming a parent that will alter the trajectories of their lives. Generations of individuals, or cohorts, can also experience events that shape the social fabric of the societies in which they live – a war, for example, or a global pandemic. These life events can influence the aging process of an individual as they transition into these new periods of their life.

The social determinants of health (SDoH) are a broad range of factors that affect the health and well-being of individuals and the population at large. These factors encompass economic, environmental, personal, and social dimensions (Government of Canada, 2023). Many of the SDoH are interrelated, and include factors such as:

- Wealth, income, and social status
- Paid employment and type of work
- Level of education and literacy skills
- Childhood life events and experiences
- Built environments, housing, shelter
- Social networks and supports
- Health and lifestyle behaviors
- Access to healthcare services
- Biological and genetic factors
- Sex and gender
- Culture
- Race and racism

The SDoH can have varying impacts on the quality of life for individuals throughout their life course. Having poor or unstable access to SDoH in early life can have consequences for individuals as they age and become older. The impacts of earlier stages of life can compound the effects of abuse in older adults. Thus, when seeking to understand the capacity and needs of older adults, consideration of the SDoH and life course perspective can help us understand the current circumstances of clients, and what barriers might exist when thinking about how to improve their situation and wellbeing.

The older adult market segment may include people as young as 50, and those up to 100 and beyond, and young-old and old-old definitions may not sufficiently segment this wide-ranging age group. It has already been argued that even people of the same chronological age can have diverse health profiles and living needs.

– WHO Global Forum Innovations for Ageing Populations

> I wish we had a way that we could have a real, true partnership with a clinic - because many of these women, they come, they don't have doctors, but their needs are high and they can't always be met by a walk-in clinic. But there's the mistrust. If we had some clinic or a doctor that really understood what these women are here for, I think it would just be brilliant.

PHYSICAL HEALTH AND MEDICAL NEEDS

Older adults have different physical health and medical needs from people who are younger. This section includes information on the importance of falls prevention, avoiding frailty and building resilience, and thinking about general health and wellbeing for seniors.

The Importance of Falls Prevention

Problems with balance and dizziness can become more common as we age. Certain medications, medical conditions, or loss of strength can all impact balance and place older adults at greater risk of falling, which can lead to hospitalization and have long-term impacts on health and wellbeing.

WHAT IS THE IMPACT OF FALLS FOR OLDER ADULTS?

Fall-related injuries are associated with:

- Reduced independence
- Significant disability
- Reduced mobility
- Higher risk of being admitted to an assisted living facility
- Higher risk of premature death

Even without injury, falls can lead to:

- Depression
- Increased fear of falling
- Loss of confidence
    - o These can make daily and social activities challenging, which in turn may lead to declines in health and function and increased risk of future falls

– Source: Canadian Frailty Network

Falls Prevention Checklist

- ☐ There are handrails on both sides of any stairs.
- ☐ Staircases are kept tidy and free from any clutter.
- ☐ Carpets on the stairs are fixed firmly. There are no-slip strips on wooden and tiled stairs.
- ☐ There are no-slip strips on outdoor stairways.
- ☐ Staircases and hallways are well lit, with light switches at each end.

TIP: plug night-lights or motion-activated lights into the electrical outlets in hallways and staircases.

- ☐ There is a lamp or light switch right next to the bed.
- ☐ The bathroom light is left on at night.
- ☐ There are no throw rugs or small area rugs on the floors or stairs.
- ☐ Spills are cleaned up immediately. A sign is used to indicate when floors are wet.
- ☐ Entryways are free of clutter. Any water tracked in from outside is cleaned up immediately.
- ☐ There is a bench or chair available by the door.
- ☐ Grab bars are mounted near toilets and on the inside and outside of bathtubs or showers.
- ☐ Non-skid mats are placed on any bathroom surface that might get wet.
- ☐ Electrical cords are kept near walls or behind furniture.

Frailty is included here because it is something that should be considered when working with older adults. However, it is a medical term that may have negative connotations in a social services setting: it can be perceived as being deficit-focused, which conflicts with the strengths-based approach employed by most community-based organizations. In addition, many older adults would not consider themselves as being frail, and discussions of frailty may be met with resistance. Frailty may be a particularly difficult concept for seniors from various ethno-cultural backgrounds, as some may have different ways of talking about health that won't align with the idea of frailty.

– (Sutherland, 2022)

> "When you come into the shelter, you definitely have to be able to care for yourself but, you know, sometimes, some of our clients require a little bit of home care.

Frailty

Frailty is a medical term that is used to indicate reduced function and increased risk in older adults. Not all older adults are "frail", but our risk of becoming frail does increase with age. Those who are frail can struggle to remain independent, have difficulty recovering from minor illnesses and falls, and are at greater risk of being hospitalized or needing long-term care.

Frailty exists on a spectrum, and an individual's risk of poor health and loss of independence increases as they progress further along the frailty spectrum. Frailty can include a loss of energy and ability to engage in physical activity, and loss of cognitive function. It can also make it much more difficult for older adults to manage or adapt to social, psychological, physical, or cognitive stressors.

To help prevent frailty in older adults, the Canadian Frailty Network has created the AVOID Frailty framework. It includes five areas that older adults can focus on to help prevent frailty as the age.

Please note that the AVOID Frailty framework represents general health guidelines and should not be considered medical advice. Nor should you attempt to diagnose any of the older adults you are working with as being frail. It is included here because it provides an excellent summary of some of the things to consider when working with older women.

A

Activity

The best way to stay mobile, strong and healthy is to do activities that **strengthen your muscles**, get your **heart beating**, and challenge your **balance**. It's never too late to start! Even adults in their 80s and 90s have been known to rebuild muscle strength with regular exercise. **Activity and exercise can slow, and in some cases reverse frailty**. Remember to also let your body recharge and repair with sleep. Sleep changes as we age, but older adults still need 7 to 8 hours per day.

V

Vaccinate

As we age, our body's ability to fight off infection is reduced. **Vaccines are safe and effective**, and they greatly improve your ability to **resist infectious disease and avoid illnesses** that can cause hospitalization or lead to poorer health. Adults over 65 years of age should get the **high dose flu vaccine annually**, as well as a **shingles and pneumonia vaccine** once as an adult over age 50. Also, check that your booster shots up are to date, including **diphtheria, tetanus and pertussis**.

O

Optimize Medications

1 out of 4 Canadian adults over the age of 65, take at least **10 different types of medications**. Some medications may no longer be required, while other new medications may be needed. Have your health care provider **review ALL your medications** periodically, including prescriptions, over the counter drugs and **even vitamins and supplements**. If unchecked, **multiple medicines** may interact poorly and **cause side effects which may lead to frailty** – like poor nutrient absorption, confusion, dizziness and falls.

I

Interact

In older adults, **loneliness and social isolation** has been associated with a **45 per cent increased risk of death**. Evidence also suggests that loneliness and social isolation can **accelerate physiological aging** and may lead to several other health problems, including **high blood pressure, depression and dementia.** Older adults with strong social relationships enjoy a **better quality of life and often live longer!** Social isolation is a physical isolation from others, while loneliness is a subjective, self-perceived feeling. One can be among others, but still feel lonely. Conversely one can live alone, but never experience loneliness. Maintaining levels of social engagement that you are comfortable with as you age is very important – Join a club, take a class or volunteer in your community. **Meaningful relationships can improve your health!**

D

Diet and Nutrition

Food is medicine! As we age, we need more of certain nutrients like protein found in fish, eggs and other sources to keep muscles and bones strong. **Vitamin D and calcium** also support bone and muscle strength and may help **prevent frailty**. Eating enough good food and **getting proper nutrition** can **reduce the risk of frailty** and help you live well, longer!

The AVOID Frailty campaign is an initiative of the Canadian Frailty Network, a pan-Canadian network committed to improving care for older adults living with frailty and their family and friend caregivers. AVOID Frailty is a trademark of the Canadian Frailty Network, used under license in Canada.

The Healthy Aging Asset Index (HAAI)

The Healthy Aging Asset Index (HAAI) is a tool to help seniors, caregivers, and professionals assess the general health and wellness of an older adult. It is informed by research in the social services and health sectors, and is aligned with the AVOID framework.

The HAAI was designed and developed with the promotion of wellness in mind. It identifies the strengths, resiliency, and wellness of seniors by asking a set of exploratory questions focused on seven different areas of their lives.

The questions are used to assess how well the senior is doing in each area. These answers are then scored, and the scores are used to help determine any supports, resources, or goal-setting the senior may need. A list of available services, resources, programming, and community supports is created to help navigate next steps.

The HAAI can be accessed online through the AVOID Frailty: Program for Healthy Aging portal hosted by the Canadian Frailty Network. The portal provides clear instructions guiding users through the self-assessment process. Users have the option to save their progress and return to it later. Once they are done and submit the assessment, they will receive a customized report listing resources and interventions that are tailored to their specific needs.

Older adults can access and use the portal on their own, but some may require assistance as they begin. Training is available to help staff in community-based organizations assist seniors when navigating the portal.

Resilience

The concept of resilience is important when working with older adults, because it acknowledges that increased frailty, decreased autonomy, and changing circumstance are realities that many people face as we grow older. Fostering resilience in seniors can help them to leverage their strengths and abilities during moments of crisis or vulnerability, adapt to changing circumstances, and 'bounce back' from difficult experiences.

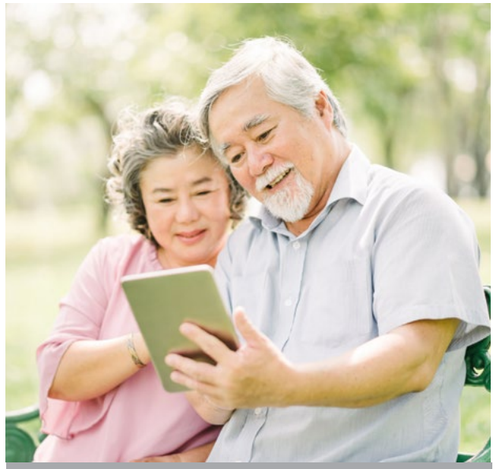
Research indicates that resilience among seniors is:

- Multidimensional: including mental, social, and physical aspects.
- Correlated with positive aging - including reduced depression, increased quality of life, and improved lifestyle behaviour.
- Associated with the ability to adapt and cope, optimism, and hopefulness, independence in activities of daily living, and better physical health.
- Highest in those with strong social supports and community connections.
- Often measured using considerations of control, autonomy, self-realization, and pleasure.

USING TECHNOLOGY

The use of computers, internet, social media, and smartphones is commonplace in our everyday lives. People are increasingly comfortable going online to manage their finances, communicate with one another, and make purchases – in fact, many services can now only be accessed online. Even though more than half of all seniors own a smartphone (Statistics Canada, 2023), accessing resources online can still be a barrier for older adults who may not know how to navigate webpages, or feel uncomfortable sharing private information over the internet. Gathering information about potential resources may be difficult if older adults have poor digital literacy skills and are not familiar with using computer technology. They may need support in this area, particularly if they are attempting these things for the first time.

Older adults are also a key target for fraud and scams: fraud is the number one crime against seniors in Canada (Government of Canada, 2019). Helping older women learn how to use technology safely can be an important part of their security and independence moving forward.



> "Because it's not only having the knowledge to access the benefits, it's also being able to navigate the technology where all these benefits now are, right? So, it's not just "Oh, go down to Service Canada and get this package," because Service Canada, it's not a storefront anymore. A lot of times, you go there and you could sit at a computer, and then you're accessing services. So, in a way, that's not helpful because they have to have the knowledge to access that technology, right?

Senior Fraud Alert is an online educational tool created by YEG Seniors Alliance and the Edmonton Police Service. It is an easy to follow, self-paced course that can help seniors protect themselves against frauds and scams.

TIPS AND SAFEGUARDS

- Never tell another person your PIN or account passwords and take care to cover your hand when entering your PIN at bank machines and when making store purchases.
- Safely dispose of old bills and statements - shredding is best.
- Do not click on pop-up windows or respond to e-mails, open attachments, or go to Website links sent by people you do not know. Your bank or credit union will not send you anything by e-mail unless you ask them to.
- Never give out your credit card, bank account, or personal information to someone over the phone, at the door, or over the Internet unless you know the person or organization you are dealing with, or you made the contact.
- Do not sign an agreement or contract to buy anything without giving yourself time to think it over. If a salesperson insists that an "offer" is "time limited" and you must decide in that moment, it is probably better not to buy.
- Be suspicious if someone you don't know asks you to send them money or a cheque, or to return money they "accidentally" sent you.

Source: Government of Canada

4. DIVERSITY OF EXPERIENCE: THE IMPORTANCE OF AN INTERSECTIONAL LENS

When we refer to ‘seniors’, we are not talking about a homogenous group: someone who is 60, for example, will have different needs and desires from someone who is 95. It is a demographic with the widest possible range of ages, socio-economic situations, cultural and linguistic backgrounds, family dynamics, life experience, sexualities, and physical and mental abilities. Seniors have diverse experiences and backgrounds, living arrangements, strengths, aspirations, support systems, levels of education, needs, and desires.

Working with older adults means recognizing the realities of people’s lives and how their different life experiences may have impacted them over time, rather than assuming that all seniors are the same, or need the same things.

It is also important to remember that structural barriers are experienced differently across the lifespan, and that these barriers not only compound over time, but have a different impact on seniors than on those who are younger. Age, in addition to gender, racialization, sexuality, disability, and other intersecting realities, also plays a role in the barriers an individual faces to inclusion, full participation, and equality of opportunity.

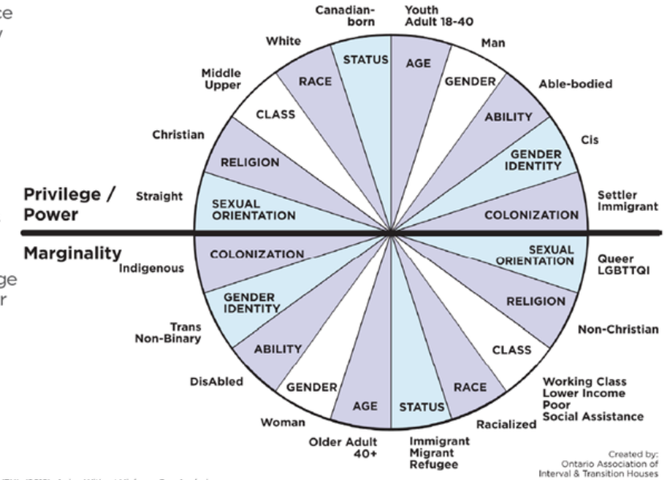
An intersectional approach appreciates diversity and acknowledges that multiple forms of oppression can be experienced simultaneously at the individual and structural levels.

In addition to the intersecting identities outlined in the diagram above, older women may also be struggling with mental capacity or cognition; declining physical health, chronic illness, or multiple medications; language barriers or low literacy; and/or loss of autonomy or independence.

It is also worth noting that the older a woman is, the more likely she is to be impacted by her age as an identity: an older woman in her 60s does not experience ageism in the same way as someone in their 80s.

Why is an intersectional approach important when working with older women?

Older women who experience violence come from a variety of communities with diverse needs, backgrounds, and experiences of systemic oppression. Below are some of the intersecting identities and the correlating positions of privilege/marginality which may impact the way an older woman experiences violence and your services. Understanding and challenging your own privilege and preconceptions and their relationship with institutional and systemic oppression is a key element of providing effective, respectful service to older women from a variety of backgrounds and experiences.[2]



Created by: Ontario Association of Interval & Transition Houses

1 Ontario Association of Interval and Transition Houses (OAITH). (2018). *Aging Without Violence Gap Analysis.*
2 Ontario Association of Interval and Transition Houses (OAITH). (2018). *How Does Intersectionality Work?*

Source: OAITH (Oct 2018). Unique barriers exist for older women experiencing violence

“A large proportion of immigrant and refugee seniors experience difficulty in finding employment due to the interplay of various social determinants of health, including limited language proficiency and health and mobility challenges. They may become financially dependent on their children or grandchildren, which can pose limitations on their ability to participate in activities outside of the home.”

–(Johnson et al., 2021)

**Name has been changed to protect confidentiality*

» ONE SENIOR'S STORY

The Elder Abuse Resources and Supports (EARS) team with Catholic Social Services contacted the Sage Seniors Safe House about a senior who needed shelter. EARS had been contacted by a concerned social worker from a dialysis unit. A 70-year-old patient, Kiran, disclosed to the unit social worker that her family had planned a holiday in September to their country of origin in South Asia and had only purchased a one way ticket for her. The intention of the family was to leave her behind in South Asia. Kiran did not want to move back there, and the social worker was concerned about her healthcare needs while in the other country.

The EARS social worker quickly arranged for a meeting to take place between Kiran and the Safe House Case Management Coordinator working specifically with seniors from South Asian communities during one of her dialysis appointments. Kiran told the Coordinator that after her husband had died, she was sponsored by her adult child to come to Canada - 15 years ago. Kiran was kept busy with the arrival of her grandchildren, and she helped out around the house. Once the children became teenagers and no longer required childcare, Kiran was left alone in the house for many hours. The only time she left the house was to attend the dialysis appointments that began a year ago, on her own using DATS. Kiran also told the Coordinator that her son and his wife fought a great deal about her, and she felt it best to leave the home.

Working with the dialysis unit social worker, the Case Management Coordinator and the Safe House Intensive Case Manager organized Kiran's admission into the Safe House. Kiran agreed that she needed to leave the home before the trip to South Asia, but was afraid to let her family know that she planned to leave. As soon as a space became available, Kiran packed a small bag that she took with her to her dialysis appointment, and instead of returning home she went to the Safe House.

Kiran stayed at the Safe House for 90 days. While at the Safe House, the team learned:

- She did not have a Canadian bank account;
- Her family member was charging her rent that she was paying from her savings because she didn't have an income;
- Her family member kept her Permanent Resident Card and other identification;
- She was not allowed to attend English classes;
- She was not connected to her faith community;
- She had never been to a grocery store since coming to Canada; and
- When she was left home alone the TV would be left on YouTube and she was never shown how to access other programs or channels she was interested in.

During her time at the Safe House, staff helped Kiran connect with cultural support through the Multicultural Health Brokers; apply for the financial benefits she was entitled to; open a bank account; retrieve her Permanent Resident Card from her family member; borrow a walker through the Red Cross Health Equipment Loan Program; access Home Care for support with medication delivery; secure affordable seniors housing; and access furniture and household items through the Family Violence Prevention Centre with Edmonton John Howard Society.

Once Kiran transitioned to her new home, she worked closely with both the Follow-up Support Coordinator and the Case Management Coordinator for the South Asian Community. Kiran was able to access a laptop and affordable internet services that enabled her to connect with her children, family members, and friends outside of Canada. She was connected to a volunteer through Home Care, language classes through the Mennonite Centre for Newcomers, and signed up for on-line computer classes offered in her language.

The Case Management Coordinator helped Kiran become familiar with her neighbourhood, including locating her bank's neighborhood branch and the local grocery store that provides imported foods she is familiar with. Kiran has made friends with her neighbours, one of whom is a former Safe House client who has been a strong source of support to her and has become her emergency contact. Kiran is now living independently, free of the control and abuse she experienced, and having all of her needs met.

5. DIFFERENT DYNAMICS, DIFFERENT CONSIDERATIONS

Many older adults seeking shelter from abuse are dealing with financial, housing, and health systems that they have never had to deal with before, and they simply do not know how to navigate those systems. And many of them, for the first time, are having to do these things alone. For example, older women may have lived in the same home for decades, and be afraid or uncertain about living somewhere else. They may never have worked, or managed their own finances, or know what resources are available to them.

The supports that exist for seniors are often difficult for them to access, and in many cases, are insufficient for their needs. Government supports also have long wait times, which can put the senior in a precarious position. It is difficult for older adults to look after their general wellbeing if they have an immediate basic need (health, housing, financial) that is not being met. There is also a lack of senior-specific subsidized or affordable housing, placing seniors who are in need of housing in a challenging situation that could further jeopardize their health and safety.

Seniors' benefits have not kept pace with the cost of living and women relying on them may be living in poverty. This problem is exacerbated for younger seniors in need of benefits, because resources are limited for those under age 65. Older women are more likely than men to have worked in part-time or low-paying jobs and have had their work life interrupted by caregiving: as a result, they are less likely to have a pension or retirement savings.

Some seniors will be carrying a lot of debt, some might be unable to afford their prescriptions, and many will be overwhelmed by having to cope with these challenges.

> "I feel like poverty is a huge issue. Like, they've worked all their lives and something has happened to them, or they've become ill or injured…so now they're in this situation where they're experiencing poverty, and they're having to go and find housing, and of course, there's such a scarcity of housing. And then, some of them really need supportive housing, you know…or that whole network of supports. All of that takes time.

The risk factors of abuse are not the same for seniors as they are for younger women. For example, a younger person who is pushed may develop bruising, but an older adult in the same situation could break a bone, which could have serious long-term repercussions on their health and mobility.

Seniors also tend to fear the loss of autonomy that is associated with deteriorating physical and/or mental health. This is often expressed as a fear of dependence, fear of becoming a burden on friends and family, and fear of social isolation. This fear can be particularly debilitating if their abuser is also their caregiver or in a position to have their cognitive capacity questioned.

Traditional beliefs about marriage, gender roles, and a sense of familial responsibility can prevent older women from reporting abuse. Adult children and grandchildren are commonly the perpetrators of elder abuse, and senior women can feel responsible for the behaviour, shame about the state of the relationship, or fear that reporting the abuse will result in total loss of contact.

» ONE SENIOR'S STORY

A woman in her 70s had been contacting the Sage Seniors Safe House about once a year for years, looking for support in leaving an abusive relationship involving her husband and son. She had been a homemaker all her life and had little to no involvement in the family's finances. Her husband had always been verbally and physically aggressive, but nothing she couldn't handle until he retired and she became more frail. Once her husband retired, her freedom became increasingly limited to the point that she would stay confined in a room all day or risk getting yelled at. Her daughter had offered to help the family by taking her mother to medical appointments and cleaning the house, but her father refused and would not allow their daughter in the home.

Over the years, the woman has been referred to the Seniors Protection Partnership, who were able to go to the home and witness the abuse firsthand and see it progress. The woman has been offered Safe House residence as an option, but because she has never lived alone or managed her own finances this option did not feel like a good solution to her. This year, with the help of her daughter and the Seniors Protection Partnership team, she was able to obtain an Emergency Protection Order against her husband and son after an incident of physical abuse. Since then, she has been connected with the Intensive Case Management program to assist her in attending court, completing her taxes, securing her bank account and finances, making a Power of Attorney and Personal Directive appointing her daughter as the agent, getting Home Care services in place, and applying for a lodge.

There is still a lot of work to be done to secure her safety, but she has already been able to attend medical appointments and reports that although she misses her son, she is enjoying the peace and quiet in her house.

6. WHAT IS ELDER ABUSE?

Elder abuse is the mistreatment of older adults and is a violation of their human right to a dignified life (WHO, 2022). Like domestic and family violence, elder abuse is characterized by a relationship of trust or dependency, and a misuse of power between the abuser and the senior.

It is not just physical: elder abuse is any action or inaction that jeopardizes the health or wellbeing of any older adult, including:

- Physical abuse
- Sexual abuse
- Psychological abuse
- Financial abuse
- Medication abuse
- Neglect

Older adults can and often do suffer from multiple forms of elder abuse. A recent study (Burnes et al., 2022) estimates that in communities across Canada, the prevalence of elder abuse is 10% among adults aged 65 and older. The actual prevalence of elder abuse is likely higher, as many cases go unreported. As the Canadian population becomes older, there is a growing concern that the prevalence of elder abuse will also increase.

Personal risk factors can also increase the likelihood that a person may experience elder abuse. Previous abuse or maltreatment at earlier stages in life has been linked with an increased chance of elder abuse (Burnes et al., 2022). Being a member of a visible minority, having mobility issues, or mental health issues such as depression, and residing in a shared living situation can also contribute to a person becoming a victim of elder abuse (Burnes et al., 2022; McDonald, 2018).

Most often the abuser is a family member or partner but may also be friends, roommates, or caregivers – someone who is close enough to have influence or control over the victim. Abuse includes using name calling, threats, yelling, put-downs, or physical intimidation to control the senior's actions or decisions. It also includes taking money or possessions without permission, and using coercion to have a senior sign documents. In many cases, older adults feel they have to give in or agree to something in order to avoid escalation or to ensure their safety. Victims of elder abuse may not want to see their abuser face punishment or consequences because of the abuse, particularly if the abuser is an adult child or grandchild.

Signs Of Abuse

Older adults being abused may become withdrawn, depressed, and isolated. They may have financial difficulty, unexplained injuries, anxiety, or difficulty sleeping. They may have changes in hygiene, nutrition, or medication or experience diminishing self-esteem.

Some Effects Of Abuse

Abused or neglected older adults have a 200% increased risk of early death. The stress of living in an abusive situation shortens an older person's life and can significantly increase the person's chances of becoming ill or may make other health problems worse.

Overlooking Warning Signs

Sometimes signs of abuse are mistaken as a part of growing older or may look like other health conditions. For example: mental confusion, depression, or anxiety resulting from abuse or neglect may look like dementia. People may not realize that sometimes older adults are experiencing frequent falls or have long-term pain because they are being abused or neglected.

Elder abuse is a form of discrimination that has been shown to have negative impacts on seniors' mental health (Sabik, 2013), physical health (Bond et al., 2003; Bowling, 1999), and vulnerability.

> "Women who are older, experiencing violence…it's the nature of the violence. You know, a lot of times it's a family member, it's a granddaughter, it's a nephew, or it could be financial abuse, you know, them not being treated well, so I think the nature of the abuse.

> "Some of them are facing a lot of financial abuse, and it's usually – they identify it's their children. Or they're caring – they're still caring for their adult children. So, "I should go back because what are they going to do?" type of thing.

7. SOCIAL CONNECTION AND ENGAGEMENT

The terms social isolation and loneliness are often used interchangeably, as though they are the same thing or always go hand-in-hand. But they are actually very different conditions: social isolation is about *interaction*, whereas loneliness refers to *connection*.

Social isolation refers to a lack of meaningful interaction with other people. A senior who is homebound, for example, might be socially isolated because they have limited or no contact with other people. But someone whose days are full of errands and activities might also be socially isolated: going to the grocery store, library, or yoga class may involve interacting with other people, but those interactions do not provide a sense of connection, community, or support.

For information on in-person, online, and phone-based programs available to seniors in the Greater Edmonton Area, visit mysage.ca to access the Directory of Seniors Services or edmontonsouthsidepcn.ca to explore the Seniors' Centre without Walls.

Loneliness, on the other hand, is much more subjective: it is a feeling that has to do with how connected we feel to others (or even one person). A senior who is homebound might have a child who visits every Sunday, or meet with their coffee group on Zoom once a week, and that is enough for them. Someone whose days are full of errands might be taking that yoga class with a group of old friends they look forward to seeing every week.

Someone can have multiple social interactions a day and still feel lonely, or see no one but a close friend and feel socially connected. Social isolation and loneliness will look different for different people, and what it looks like can change over time. But both conditions negatively impact our physical and mental wellbeing: studies have shown that people who are socially isolated and/or lonely are at greater risk of depression, suicide, substance abuse, and cardiovascular disease (Stauch, 2021). Research has found that chronic loneliness is as bad for our physical health as smoking cigarettes (Holt-Lunstad et al., 2010) and worse than obesity and diabetes (Goldman, 2016). Seniors who are socially isolated are more likely to engage in negative health behaviours, have an increased risk of falls and hospitalization, and are more susceptible to elder abuse.

Older adults can experience unique age-related changes that impact their ability to connect with family, friends, and others, including changes in physical mobility, income barriers, chronic health conditions, depression, and transportation barriers. Immigrant, refugee, and newcomer seniors without established communities are also at greater risk of social isolation and loneliness, particularly if language is a barrier (Johnson et al., 2021). These risks were exacerbated during the COVID-19 pandemic when social isolation was mandated and loneliness deepened, and many seniors continue to struggle with substance abuse, mood disorders, and other mental health issues as a result.

A sense of purpose can also be particularly important for older adults: believing that they are needed and valued can not only be a motivating factor for seniors, it can have a significant impact on their mental health and wellbeing. Being removed from their homes and families may disrupt that sense of purpose or place in the world – particularly for older women who have embraced a traditional understanding of gender roles – and this can increase their risk of loneliness, anxiety, and depression.

> "They're grieving. I think they're grieving their family members. Things didn't work out. Or their relationship. They miss their grandchildren. They have bigger families than a young person. They already have – some of them have grandchildren and great grandchildren, and they miss them. So, there's grieving a little bit while they're in shelter. And they may have been isolated.

Increasing the number of interactions a senior has will not necessarily alleviate their social isolation or loneliness. But encouraging social connection, engagement, and the development of supportive social relationships can have a significant impact on the health and wellbeing of older adults.

Seniors centres and other community-based organizations often provide low-commitment (e.g. drop-in), low- or no-cost programs that can be an excellent place to start. Research has also shown that email communication and online groups or classes can help increase social connection and decrease feelings of isolation and loneliness (Cotton et al., 2014; Erickson and Johnson, 2011).

Approximately 20% of seniors live with a mental disorder (excluding dementia, which affects 7% of seniors in Canada), including anxiety (5-10%) and alcohol-related disorders (6-10%): depression - which is under-reported - impacts at least 15% of seniors.

– (CURAC, 2017)

Q & A

ASK THE EXPERTS

The ways in which elder abuse differs from other forms of family violence can be complex. In this section, we share a conversation with Bernice Sewell and Michele Markham, who have been working with older adults experiencing elder abuse for many years.

Bernice Sewell is a registered social worker with over 40 years of experience. Bernice worked in a women's shelter for 11 years before joining Sage Seniors Association, where she has worked with older adults and issues of elder abuse for 23 years. She was instrumental in the development of Sage's Seniors Safe House, and is a strong advocate for person-centred programs that meet the needs of the client.

Michele Markham is a registered social worker and manager of the Sage Seniors Safe House. As part of her role, Michele participates on the management committee of the Seniors Protection Partnership, a collaborative intervention team that responds to high risk abuse cases. Michele is a board member of both the Alberta Elder Abuse Awareness Council and the Canadian Network for the Prevention of Elder Abuse.

How does elder abuse differ from other forms of domestic or family violence?

Bernice: First, the abuser is often different, so the impact is different. It's challenging to leave your spouse in domestic violence situations, because you love them, and they may be the father of your children. But when the abuse is coming from an adult child that you raised – who is part of your flesh and blood – you might feel guilty that they have turned out this way and responsible for the way they are treating you. There are different dynamics in an elder abuse situation.

Michele: Yes. And many of the older adult women who have come into our shelter have a prior history with intimate partner violence. So, when the person who is harming them now is their adult child – who grew up in that environment – they may be dealing with feelings of guilt and responsibility. If we think about family violence on a spectrum from child abuse to intimate partner violence, and then elder abuse, someone who is 70 years old could be coming to us with a very complicated family history.

But the dynamics can be different even when the abuser is an intimate partner – we have worked with people who had never experienced violence in their relationship, but then something changed health-wise with the spouse, and now there is violence. That can complicate things, because now the senior is adjusting to a major change and grieving the loss of a 20 or 30 year marriage.

Bernice: There have been cases where a couple has been married 50 years, and then the spouse develops dementia and that can lead to abuse. And it can be sudden, but it might also be a slow onset. So, someone is living in a situation that is okay, and then slowly over time, with the progression of an illness – that you're not really even aware is happening – anger starts to come out, and shoving starts to happen, and other violent tendencies begin to show. And it's not a situation where it's good today and bad tomorrow: it can happen slowly over time, and it can take the victim a while to understand or recognize that maybe there's something they should seek help for.

Michele: Yes. Abuse can also emerge after a change in other circumstances - we know, for example, that retirement can change things for people. There are a number of complicating factors that exist within elder abuse that aren't necessarily present with other forms of family violence.

Can you give an example of how retirement changes things for people?

Michele: We have seen cases where a spouse has retired, and their sense of identity has been impacted. And then an addiction started, the alcohol started, the change in behaviour started. They don't have any social connections, and the wife becomes the target of their unhappiness and violence. And if you've been socialized as the caretaker, you wonder what you're doing wrong that makes your husband treat you this way?

Can you tell me a little bit more about how abuse is different when it is coming from an adult child or grandchild as opposed to a partner or spouse?

Bernice: The abuse can be different for different reasons. Domestic violence often involves possessiveness, like "I love you so much that I can't stand another man looking at you, so you better watch how you behave", while an adult child might be abusing their parent financially, or saying "If you don't do what I want, I won't let you see your grandkids". So, it's not about possessive, jealous love and obsession. It's about other things. They might be mad at their dad or mom because they were abused by one of them when they were young, and the other parent was not able to protect them because they were also experiencing abuse. And then they grow to be adult children and blame that parent for not protecting them. So, the dynamics that surround the abuse are totally different.

Michele: Like when the adult child is a caregiver for the senior - they have more opportunity for power and control. We've had an older adult whose son left her in a bed in a dark room for over 24 hours.

Bernice: Yes, or leaving the person in their bath water until they promise to give them their bank card - that kind of stuff. So, taking advantage of some of that vulnerability as well.

Michele: And for many of the older adults, they know things were not great for their children growing up, and they carry a sense of guilt because of it. So, if their adult child is now dealing with mental health or addictions issues, they think "I need to help them. I'm keeping them alive. I have to give them all my money".

We had an older adult whose children would use the fact that she had had other children die because of addiction to get what they wanted from her. They're dealing with their own mental health and addiction, and they're doing what they need to do to survive, and they're trapped in this cycle of relation - this is how they relate: "I'm desperate. If you don't give this to me, I'm going to freeze to death just like so and so did" or "I'm this way because of what happened". We see that a lot. It's very, very entangled.

How do concerns about capacity or dependency impact an abusive situation for older adults? For example, if the abuser holds power of attorney for the victim.

Bernice: Well, then the abuser has the power. And if you don't have capacity, who's going to believe that you're experiencing what you say you're experiencing? It can put others who are trying to help in a precarious position. For example, if somebody was to come to our organization and tell us that they're being abused by their guardian or power of attorney or whatever, they don't have the capacity to make those decisions - it leaves us in a bind of a situation. Or we've worked with people who have never been deemed to not have capacity, and then slowly, as we worked with them, it becomes clear that the abuse is all in their head and it's their dementia, their lack of capacity, that has them in this situation. It adds a whole different dynamic.

Michele: Where this is particularly pertinent for shelters is where ageism and cognition intersect - just because a person is experiencing some diminished cognition does not mean they're not their own decision maker.

Bernice: And/or that they lack capacity in all areas.

Michele: Exactly. So, I think it's important for shelters to be aware that an older adult may struggle with some short-term memory or what have you, but that doesn't mean that they need a medical intervention. That doesn't mean they need their decision making taken away from them. That's where we really need to check our ageism and our bias.

We've had people in our shelter who have scored very poorly on assessments and could have been deemed as lacking capacity and had their decision making taken away, but didn't. They had the support surrounding them that they needed to live safely and be okay. So this is my caution for shelters: don't assume that every older adult is struggling with cognition issues. Don't assume that they don't have the ability to make their own decisions. And don't assume that because you turned 65 or whatever, you're suddenly going to start making really good, safe decisions. The person who made reckless decisions at 40 will likely make reckless decisions at 70 and 80. And that's okay.

Bernice: And they still have the right to make those decisions.

Michele: Absolutely.

Bernice: I think the other thing that's important to know is that there are illnesses that can create some short-term memory issues and other challenges. If a person came into the shelter and we had no knowledge of them before and they didn't seem to have any ability for short-term memory, we might assume that that's how they are, but they may have a urinary tract infection, which can have that effect. So, there's other aspects to working with other adults that are important to keep in mind.

Are there different risk factors that need to be considered when completing assessments for older women experiencing elder abuse?

Bernice: Health is one, for sure. Anyone with limited physical abilities, regardless of age, can have additional challenges and risk factors because they might be more vulnerable in an abusive situation. But some things could be more lethal for a senior than they would be for a younger adult. If a younger person is pushed, they're not going to break a hip, but an older adult might. That can actually be a death sentence - if they're not able to move, that can lead to pneumonia, etc. The point being that something that seems to be a less severe physical assault can actually be much more harmful to an older person.

Michele: It's important for people working in shelters to know that the danger assessment that is done is not evidence-based for older women. They need to pay attention to the risk factors and ask "is this person living with a mobility issue? How isolated are they?". They really need to pay attention – and be careful not to let ageism colour their perspective.

Can you give me an example of how ageism may impact someone's assessment?

Michele: "Older women aren't at risk - who's going to kill a senior? Who's going to sexually assault a senior?" Or "I don't need to ask that question about strangulation. It's her son who's abusing her."

Bernice: "Come on, he just shoved her out of the way. He didn't mean to hurt her."

Michele: "I don't need to ask about sexual assault because it's her son who's abusing her."

What if the abuser is a caregiver who may be experiencing burnout?

Bernice: There's no evidence to show that caregiver burnout is a factor in elder abuse. If a caregiver is going to be abusive, it's not about burnout – it's about power and control. It's about their need. It's not about burnout.

Michele: It's kind of like saying, "Oh well, she had post-partum depression, so of course she shook her baby when it was crying." No. Maybe the caregiver is struggling with addictions and mental health issues, and they don't have the supports they need. That still doesn't mean they can hit mom out of frustration - that's about power and control.

One of the guiding questions for this project has been what do shelters need to improve their ability to meet the needs of older women? How would you answer that?

Bernice: I think understanding all the different dynamics that come with someone who's older. So, understanding all of the things we've talked about, including ageism, which is very real, and they really have to deeply understand it.

Michele: The risk of lethality is another thing. A report from Peter Jaffe found that one in five women murdered in Ontario was over the age of 55. And when it's an older woman in a domestic violence relationship and there's lethality, it's more likely to be a murder-suicide. So, even though the danger assessment is not evidence-based for older adults, shelters really need to pay attention to that risk factor. And like Bernice said, checking the ageism. We often get called when there's an older adult in the shelter, because people think they need to come to us. Well, not necessarily. You could be the best fit for them because of safety, because of X, Y, or Z. And we are happy to work with you, but don't assume they need to be in our shelter because they are older. Are the needs different, are the resources different? Probably.

Bernice: Yes, they most likely are. If somebody's over the age of 65, the available resources might be different from what the shelters are used to. Different health needs can also be a factor - like it's great to have foot care available for someone who is diabetic. All of those things can play into it.

One of the things I've heard you saying too is the importance of considering the whole person. There's a whole lot of life experience between 40 and 70, for example, so considering the whole person really means considering the length of their life and the different experiences they may have had over time.

Michele: And length of time living without actively confronting trauma. It becomes deeply ingrained. So, expecting a 70-year-old woman to cut off her abusive daughter is not realistic. It's about harm reduction and safety planning, and how can you have a relationship? You want to give her money? Okay, how can we do that so you're still getting your needs met?

How do you balance the risk and heightened danger that may be a factor because of a person's age and physical condition against the agency of that woman saying, "I will not cut off the relationship with my daughter"?

Bernice: You talk with them about it. They have the right to make that decision, but they also have to have their own needs met. They need to be able to pay their rent. They need to be able to afford food. So, we could help them find a way to do that, but still have $100 a month left to give to their daughter if they choose. So, you help them come up with a plan. You want to see your daughter? Maybe you don't invite her to your home where she feels she can come and go as she chooses. Meet her somewhere else. Don't give her a key to your door, right?

Michele: We very much understand – we affirm that, "We know you love your kid. So, how can you go forward in a relationship where you are still safe, and your home is not in jeopardy?" We provide as many suggestions and options as possible, and most of the time, it works. And sometimes it doesn't work – the person is not able to maintain that boundary even with all the possibilities. They're just too entrenched in this way of being with that person.

Bernice: And sometimes the housing provider will take responsibility by saying, "No one can come and stay with you. That's our rule. It's not up to you." It takes that boundary right out of their hand, right?

Michele: That's the option of last resort that typically works really well.

Bernice: And then sometimes it doesn't. That's the heartbreaking piece.

SECTION II

RESOURCES AND INFORMATION

1. UNDERSTANDING SENIORS BENEFITS/FINANCIAL SUPPORTS

Accessing resources and services for seniors can mean navigating what are often complex systems that can be confusing and overwhelming. Simply accessing seniors' benefits, for example, can mean dealing with all three levels of government and navigating multiple requirements and different expectations. This can require some additional time and support, particularly when older adults are dealing with unfamiliar systems and processes for the first time.

Seniors' benefits provide a basic income for older adults, something that is becoming increasing necessary, as over 30% of Canadians are approaching retirement with no savings at all, and a further 19% indicate that they have less than $50,000 set aside for retirement (Lovett-Reid, 2018). This concern is compounded for older adults who may be carrying significant debt loads into their later life, and others who have experienced job precarity and income insecurity over their life course.

Please note that the resources, services, and financial supports available to older women may differ according to age.

The benefits and financial supports available to older adults are listed in alphabetical order on pages 43-44. The most commonly accessed supports for older adults are:

GOVERNMENT OF CANADA

Old Age Security (OAS)

A monthly pension available to people 65 years and older. The amount received depends on the senior's income and how long they have lived in Canada (a minimum of 10 years). OAS is taxable income.

Guaranteed Income Supplement (GIS)

Seniors (aged 65+) who receive OAS may also be eligible for GIS if their annual income is below the income threshold. GIS is a non-taxable benefit.

Canada Pension Plan

The Canada Pension Plan (CPP) is available to seniors (60+) who have made at least one payment into the CPP. Seniors can continue to work while receiving CPP. CPP is taxable income.

GOVERNMENT OF ALBERTA

Alberta Seniors Bene it (ASB)

Financial assistance for low-income seniors (aged 65+) receiving the full OAS pension. Generally, this means that the senior must have an annual income of $31,080 or less. Seniors must be a Canadian citizen or permanent resident and have lived in Alberta for at least three months to be eligible for ABS. ABS is a non-taxable benefit.

THE IMPORTANCE OF INCOME TAX

Seniors benefits are calculated and paid based on the previous year's income (January – December), so up-to-date tax filing is a requirement, and often the first step when helping older women access benefits. It is not uncommon for a senior to need help filing five or more years of taxes - which means that they have not been maximizing their income for some time, and are very likely living in poverty.

The federal government supports a Community Volunteer Income Tax Program (CVITP), helping community-based organizations host free tax clinics for people with a low-income (less than $35,000 for an individual). The majority of clinics operate during tax season (March-April), but some are available throughout the year. You can call 211 or visit the Government of Canada's website to learn how to access Income Tax Clinics.

Older women (aged 65+) leaving abusive spouses can sometimes face a system challenge regarding their federal pensions. Seniors are required to complete and submit a Statutory Declaration of Legal Spouses through Service Canada in order to have their personal pension income (specifically the Guaranteed Income Supplement) adjusted accordingly for a single person. Unfortunately, there is a five-month waiting period between the submission of the Declaration and the individual's income being adjusted. This delay can impede a senior's ability to acquire alternate accommodations.

Shorter wait-times for pension adjustments are only considered when a separation is involuntary and beyond the senior's control because of medical issues. Service Canada does not recognize a restraining order or proof of abuse as sufficient evidence to waive the waiting period, because the separation is considered voluntary and within the senior's control. Until this changes, older women leaving abusive spouses will continue to experience difficulty when seeking affordable housing, and increase the length of time they may need to be sheltered.

ALPHABETICAL LISTING OF SENIORS BENEFITS/FINANCIAL SUPPORTS

Alberta Seniors Benefit

The Alberta Seniors Benefit program is based on income and provides a monthly benefit to eligible seniors to supplement federal programs, including Old Age Security and Guaranteed Income Supplement. To be considered for this benefit, seniors must submit a Seniors Financial Assistance application. This application also automatically enrolls the senior in the Dental Assistance for Seniors, Optical Assistance for Seniors, and Special Needs Assistance for Seniors programs.

Alberta Aids to Daily Living (AADL)

Alberta Aids to Daily Living (AADL) funds basic medical equipment and supplies to help Albertans with long-term disabilities, chronic and terminal illnesses, stay independent in their communities. AADL is a cost-share program. Clients pay 25% of the benefit cost up to a maximum of $500 per family per year. If the client receives provincial income assistance, or their income is below qualifying thresholds, they may be exempt from cost-share payments.

To obtain AADL funding, the client must be assessed by an approved healthcare professional. That person determines what equipment and supplies they can get through the AADL program. To find an approved healthcare professional, call HealthLink at 811 and let them know what kind of equipment or supplies are needed, and ask for an AADL Authorizer or Specialty Supplier.

Alberta Blue Cross Coverage for Seniors

The Alberta Health Care Insurance Plan (AHCIP) provides seniors 65 years of age and older premium-free coverage for prescription drugs and other health-related services not covered under the AHCIP. Coverage includes prescription drugs listed on the Alberta Drug Benefit List, supplies for insulin-dependent diabetics, ambulance services, clinical psychological services, home nursing care and chiropractic services. Seniors may be responsible for a portion of the cost of these health benefits. 70% of prescription drug costs are covered, and seniors generally pay a maximum of $25 per prescription or refill.

Allowance

A monthly benefit for low-income seniors (aged 60 - 64) whose spouse or common-law partner is eligible for, or currently receiving, the Old Age Security (OAS) pension and the Guaranteed Income Supplement (GIS).

Allowance for the Survivor

A monthly non-taxable benefit to low-income widowed spouses who are not yet eligible for the Old Age Security (OAS) pension.

Canada Pension Plan (CPP) Retirement Pension

An older adult may qualify for a CPP retirement pension if they worked, have made at least one valid contribution (payment) to the CPP, and is at least 60 years old. Although the CPP retirement pension was originally intended to start the month after the senior's 65th birthday, they can begin receiving their CPP retirement pension any time after age 60. Older adults do not have to stop working to receive their retirement pension. The monthly payment is smaller if they begin receiving it before age 65, and larger it is taken after age 65.

Community Aids for Independent Living (CAIL)

CAIL is a program within the Allied Health Community (Edmonton Zone) portfolio that helps individuals who have chronic illnesses or disability, or who are terminally ill, to obtain permanent medical equipment and/or supplies. The primary funding source accessed is Alberta Aids to Daily Living (AADL). A Registered Nurse or Occupational Therapist will assess clients in their homes or in one of the site offices. Appointments are booked in advance.

Disability Benefit

The Canada Pension Plan (CPP) disability benefit is a monthly payment. It is available to people who contributed recently to the CPP while they worked, and then became unable to work at any job on a regular basis because of a disability. The primary purpose is to replace a portion of employment earnings for people who recently paid into the CPP.

Guaranteed Income Supplement

A monthly non-taxable benefit to low-income Old Age Security (OAS) recipients living in Canada.

Old Age Security (OAS) Pension

This is a monthly benefit available to most Canadians 65 years of age and over, and who have lived in Canada for a minimum of 10 years.

Pensions from Other Countries

Canada has international social security agreements with a number of countries that offer comparable pension programs. These programs pay benefits when the senior retires, or if they become disabled or die. Social security agreements help people receive the benefits to which they are entitled. If the senior has lived or worked in another country, they may be eligible for social security benefits, either from that country or from Canada. For more information, contact International Operations Service Canada.

Survivor Benefits

- Death Benefit: a one-time payment to, or on behalf of, the estate of a deceased CPP contributor.
- Survivor's Pension: a monthly pension paid to the survivor of a deceased CPP contributor.

» ONE SENIOR'S STORY

A man in his 70s was connected to Sage through his sister, who had to convince him to even talk to us on the phone. He was homeless, dealing with severe depression, overwhelmed, and living with fear and shame about his situation. He hadn't filed his taxes for over 20 years.

We took the time he needed to build a trusting relationship with us, and soon he was able to let us help. We began by contacting Revenue Canada with him, so that he could obtain copies of the income statements he needed to sort out his taxes, and then connected him to a volunteer accountant who could walk him through the process. We helped him make the necessary appointments, and - more importantly - gave him the support he needed to follow through with them.

Once he was able to get his taxes straightened out, he qualified for retroactive pay from CPP, OAS, and GIS. Even though he owed money to Revenue Canada, he was able to make that payment, and to build a budget that would allow him to meet his needs. We advocated on his behalf to help him secure safe, appropriate housing that fit within the restrictions of his budget, and found him a suite that he is proud to call home.

2. BARRIERS TO FINANCIAL SUPPORTS FOR IMMIGRANT, REFUGEE, AND NEWCOMER SENIORS

In March 2022, Innovation, Science, and Economic Development Canada (ISED) *Connecting Families*, announced an initiative to connect low-income families to affordable internet service. The program includes a provision for seniors receiving Old Age Security (OAS) and the Guaranteed Income Supplement (GIS) to apply for low-cost, high speed internet service – a welcome opportunity for seniors living with a low and fixed income, who would not otherwise be able to afford access to the internet.

The program is an excellent attempt by the Federal government to increase access to technology for seniors: it is also, however, an example of how immigrant, refugee, and newcomer seniors are often further marginalized by seemingly innovative policy decisions.

To qualify for the program, seniors must be receiving the maximum GIS – which is not the case for those who have not been in Canada for 10 years, nor for those who have worked in Canada and are receiving some monies from the Canada Pension Plan (CPP).

Immigrant, refugee, and newcomer (IRN) seniors in Edmonton face increased risk of vulnerability due to systemic, cultural, and language barriers, and connection to community, resources, information, and support is particularly important for this population (Zenev and Associates, 2015).

A senior needs to have lived in Canada for ten years before they are eligible for Old Age Security (OAS), the Guaranteed Income Supplement (GIS), and the Alberta Seniors Benefit (ASB. Seniors who have come to Canada through family sponsorship are not eligible for GIS during the sponsorship period, which can be up to 20 years. Seniors who do not qualify for GIS are also not eligible for subsidized phone or internet rates. The only possible support for these seniors is Income Support (and sometimes AISH).

If a senior is in Alberta on a Super Visa, they are not eligible for any benefits or supports, including Income Support and AISH. Because of restrictions to support, they may be financially dependent on family members.

These seniors are also likely to be living with family members already experiencing poverty due to low-wage or precarious employment. The systemic barriers preventing them from accessing benefits, and the inability to work due to physical and/or language limitations, means that IRN seniors are much more likely to experience housing and food insecurity, high levels of stress, and deep isolation.

Language barriers also mean that some IRN seniors may not be able to read or understand the Latin alphabet and find it extremely difficult to navigate public spaces, including public transit. Some seniors may not be able to read or write in their first language, which can further complicate English language acquisition and application.

IRN seniors are also experiencing a very different way of doing things from what they were familiar with in their country of origin: this can be very confusing and decrease their ability to navigate needed services.

Some IRN seniors are dependent on family members who limit their mobility, social connections, and access to information. Relying on their abuser to communicate in English, for transportation, and/or to help navigate public spaces and services, can also significantly restrict access to social supports, healthcare, and other services for IRN seniors. Even if they are living with family, IRN seniors may have few people to talk to, particularly if their grandchildren were raised in Canada and do not speak their grandparent's language.

Pre- and post-migration experiences can affect both the physical and mental health of IRN seniors. Refugee seniors in particular may be living with trauma from their countries of origin and/or migration journey. They may not trust the police, healthcare personnel, or other service providers.

IRN seniors are often reluctant to bring harm or shame to a family member who is abusing them. Their abuser may also be threatening their citizenship. And many worry that if they did leave the relationship, they would truly be alone and vulnerable.

"Migration affects the accustomed family patterns which lead to changes in family members' roles and responsibilities. Consequently, immigrant and refugee seniors may lose their major roles in the family which they used to play, which may make them vulnerable to isolation."

– (Johnson et al., 2021)

3. UNDERSTANDING SENIORS HOUSING

» ONE SENIOR'S STORY

A 62-year-old man called the Safe House asking for support. He had lost his job due to a combination of health issues and COVID-19, so his only source of income was Alberta Income Supports. Because of this, he could no longer afford to live on his own, and had moved in with a friend and the friend's wife. After a few months, his friend began to control the amount of food and household items he could access, and would not allow him any privacy – he was required to keep the bedroom door open, and would get bombarded with questions every time he received a phone call. On top of this, he was living about a 1.5-hour drive from Edmonton, but needed to visit Edmonton regularly for medical appointments. He relied on this friend for rides to Edmonton, as he did not have his own vehicle.

By the time he called the Safe House, he had nearly given up all hope of regaining his independence. The Intensive Case Management (ICM) Coordinator met with the senior for an initial appointment and to begin applying for housing. Because he was under 65-years of age, he had assumed that he would not be eligible for seniors housing, so had not begun the application process himself. The ICM Coordinator submitted his housing application and followed up the next day – he was able to tour one of the seniors residences the following week, and accepted the residence. The ICM Coordinator was then able to help him request financial support for the required damage deposit from Alberta Income Supports, as well as for the cost of moving. Alberta Income Supports approved the request, and the senior was able to move into his new housing.

HOUSING OPTIONS

In Alberta, there are three streams within the continuing care system that can provide seniors with a broad range of health and personal care, accommodation, and hospitality services: home living, supportive living, and facility living.

HOME LIVING

Home Living is for people who live in their own homes, in single family dwellings, apartments, condominiums, and other seniors' independent living options. In home living, individuals are responsible for and capable of arranging any care and support services that they may need.They can access publicly funded home care services through Alberta Health Services Home Care Program.

Home Living - Life Lease

While financial requirements of the life lease depend on the particular development, residents typically invest in their apartment on a "life lease", allowing them to live in their own suite for as long as they choose. The requirement is usually a deposit of 35%-100% of the suite value before moving in. All residents pay a monthly fee to cover operating costs, such as property taxes, utilities, and maintenance of common areas.

When less than the full value of the suite has been deposited, there is a monthly rental charge to finance the unpaid balance. In one example, a suite valued at $400,000 with 50% deposited ($200,000), the monthly rent was reduced from $2,560 with 0% deposit, to a total monthly cost of $550. This fee includes property taxes, utilities, maintenance of the common area, and in the suite, and property management. Additional services that may be available for an additional cost include a range of supportive living services, including meals, housekeeping, and recreation programs.

Some developments offer long-term care facility living, which are accessed through Alberta Health Services - Community Care Access. Upon moving, or in the event of death, the amount of the original investment is refunded. No interest is paid on the initial investment. Depending on the particular life lease development, there is a deduction from 1% to 12% from the initial investment to cover re-sale and administrative costs.

When purchasing a life lease suite, the agreement should be reviewed by an accountant or lawyer for the same reasons that a professional would advise on a real estate purchase.

Seniors' Self-Contained Housing Program

Government of Alberta

This program provides apartment type accommodation to low and moderate income seniors who are functionally independent with or without the assistance of existing community based services. All suites are equipped with a refrigerator and stove.

Tenant Eligibility and Selection Criteria
Seniors whose income falls below local limits, as determined by the market for that community (refer to alberta.ca/affordable-housing-programs), who meet citizenship requirements and who are functionally independent with or without the help of existing community-based services, are eligible. Seniors are defined as persons 65 years of age or older. Seniors can also be defined as someone less than 65 years of age with special circumstances. Eligible applicants are prioritized on the basis of need according to a legislated point scoring system. Criteria used to determine an applicant's current situation and level of need includes factors such as percent of income paid to rent, emergency situations, utility responsibilities, and accessibility issues.

A tenant's rent, which includes heat, water, and sewer expenses, is based on 30% of a household's adjusted income. The tenant is responsible for electricity, telephone, and cable television, as well as any additional services they may request (e.g. parking).

SUPPORTIVE LIVING

Supportive living provides accommodation in a congregate homelike setting, where people can remain as independent as possible while they have access to accommodation and services that meet their changing needs. Supportive living combines accommodation or housing with hospitality services and other supports and care. It meets the needs of a wide range of people, but not those with highly complex and serious health care needs. Supportive living includes many different types of settings, such as (but not limited to) seniors lodges, group homes, mental health, and designated supportive living accommodations. The settings can be operated by private for-profit, private not-for-profit, or public operators. In addition to providing a place to live, services in supportive living accommodations may include meals, housekeeping, and social activities.

Supportive living residents may also receive professional and personal support services through home care. Supportive living residents pay a monthly accommodation charge to cover the costs of providing accommodations and services like meals, housekeeping, and building maintenance. Supportive living is also typically unable to serve individuals who exhibit unpredictable behaviours that put themselves and/or others at risk.

Compared with home living, supportive living provides:

- Basic hospitality services such as meals (at least one main meal per day), housekeeping, laundry, and life enrichment services on site and arranged by the housing operator.
- A common area for meals, social functions, etc.
- A safe and accessible environment.

Supportive Living - Senior Lodges

Senior lodges typically offer single and double bed/sitting rooms, meals, housekeeping and other services, and recreational opportunities for seniors who are functionally independent, with or without the help of existing community-based services. Senior lodges may be operated by private for-profit or nonprofit organizations, however the majority of lodges are managed by a housing management body through the Seniors' Lodge Program administered by Alberta Seniors and Housing.

In the Seniors' Lodge Program, applicants are prioritized on the basis of need, taking into consideration housing needs, level of support required, and the applicant's income. In some cases, applicants must also meet local residency requirements.

Lodge rates are set by the local housing management body, so they may vary between regions. To protect lower income residents, operators must adjust the monthly rate to ensure that each resident has at least $315 per month in disposable income.

Supportive Living - Dementia Care Sites

These facilities offer suites that provide specialized, secure supports for residents living with dementia. These suites are accessed privately, directly through the facility operator and are not part of the Designated Supportive Living program (although they may offer both types of suites in the same facility). In addition to the typical services found in supportive living, such as meals and housekeeping, dementia care services generally include additional nursing supports and specialized recreation programming. Each housing operator will have a different service model.

FACILITY LIVING

Long-Term Care Facilities (e.g. nursing homes and auxiliary hospitals) are specifically for individuals with complex, unpredictable medical needs, who require 24 hour on-site registered nurse assessment and/or treatment. For a small number of seniors who can no longer be supported in their own home, or in a supportive living facility, long-term care might be an appropriate living option. Long-term care may be required for:

- Complex end of life care needs
- Complex medication management
- Complex nursing care
- Inconsistent or unstable behavior that places the senior, or others, at risk.

An assessment by Alberta Health Services is required to access long-term care. Residents are responsible for the cost of accommodation or rent in long-term care, as well as for any additional care or support services requested by the resident that are not part of the care plan completed by the Alberta Health Services Case Manager. Please note that the maximum accommodation charges in long-term care and designated supportive living increases annually on July 1 based on the Alberta Consumer Price Index (CPI).

HEALTH AND DAILY LIVING SUPPORTS

For many seniors, accessing information about the services and supports available to them is crucial for maintaining personal wellbeing, a physical environment that supports healthy aging, and safety and security.

Alberta Health Services

Professional and support services are provided to clients who live in their own residences to assist them to remain independent in their homes. Clients may live in a house, apartment, duplex, townhouse, condominium or any other independent living option. Services may also be provided in community clinic settings.

Home Living provides care for clients at all ages and stages of life:

- Short-term care for those who need minimal assistance for a short time.
- Long-term care for the chronically ill and those requiring assistance to maintain health and independence.
- Palliative home care staff provide support for those at the end of life.

Home Living services include:

- Home Care Adult Services
- Home Care Volunteer Services
- Palliative Home Care
- Comprehensive Home Option for Integrated Care of the Elderly (CHOICE)
- Day Programs
- Community Aids to Independent Living

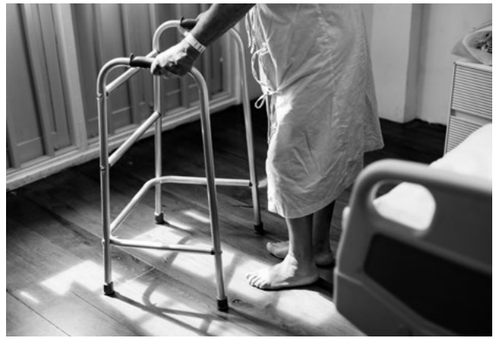
Sage Seniors Association publishes a **Directory of Senior Services** that includes a section on seniors housing in Edmonton and the surrounding area. The section includes information on the different kinds of seniors housing, listings from housing providers, and checklists of things to consider when searching for safe, affordable, and appropriate housing.

The Directory of Senior Services can be accessed online at mysage.ca, or picked up at Edmonton area libraries, seniors centres, and AMA locations. Delivery of the Directory can also be arranged by calling **780-423-5510.**

Home Care

Seniors can access publicly funded home care services through the Alberta Health Services Home Care Program. Home Care can provide in-home professional support services such as nursing and rehabilitation, and personal support services like homemaking, bathing, or grooming assistance. The Home Care program is governed by the Public Health Act's Co-ordinated Home Care Program Regulation. Alternatively, individuals can purchase personal and other support services privately.

HOME CARE	
WHAT IS IT?	Publicly funded healthcare services to help people remain well, safe, and independent in their home or congregate living setting (e.g. a lodge) for as long as possible. Home Care workers provide help with the activities of daily living that a senior is not able to do themselves (e.g. personal hygiene or medication management.
WHO IS IT FOR?	Anyone living in Alberta with a valid healthcare card can receive services, as long as their needs can be met safely in their place of residence. An assessment by an AHS case manager is required to determine eligibility.
WHO PROVIDES CARE?	Home Care providers, the client, family, and caregivers are all active partners of the care team. A case manager works with the senior to assess their needs, help arrange supports, and coordinate care and services.



THINKING ABOUT AGEISM (ANSWERS)		
3. **TRUE OR FALSE**	**T**	**F**
a. The majority of seniors (65+) have Alzheimer's Disease		**F**
b. The five senses (sight, hearing, taste, touch, smell) all tend to decline as we age	**T**	
c. Most older adults lose interest in and capacity for sexual relations		**F**
d. Older adults have more trouble sleeping that younger adults do	**T**	
e. Clinical depression occurs more frequently in older people than younger people		**F**
f. Physical strength tends to decline with age	**T**	
g. Older workers cannot work as effectively as younger workers		**F**
h. Older adults take longer to recover from physical and psychological stress	**T**	
i. Older people do not adapt as well as younger people when they relocate to a new environment		**F**
j. Memory loss is a normal part of aging	**T**	
k. Alcoholism and alcohol abuse are significantly greater problems for those over the age of 65 than those under 65		**F**
l. Personality changes with age		**F**
m. As people grow older, they face fewer acute health conditions and more chronic health conditions	**T**	
n. It is very difficult for older adults to learn new things		**F**

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