October 13, 2014

Effective practices on collaboration between affordable seniors' housing providers and mental health service providers

A report commissioned by the
Older Adult Service Providers of Calgary (OASPoC)

Lee Tunstall, PhD and Susan McIntyre, PhD

Acknowledgements

This project was made possible by funding from the Calgary Foundation and the Calgary Homeless Foundation. Thanks also goes to the project steering committee members from the Older Adult Service Providers of Calgary (OASPoC):

- Pat Cashion, Chair
- Kim Savard, Program Manager, Older Adult Team, Calgary Family Services
- Sarah Price, Director of Service, Silvera for Seniors
- Catherine Fallon, Community Outreach Manager, Calgary Seniors Resource Society

Citation information:

Tunstall, L. and McIntyre, S. (2014*). Effective practices on collaboration between affordable seniors' housing providers and mental health service providers*. Calgary: OASPoC.

Any omissions (within the parameters of our study) or errors are purely unintentional. Every effort has been made to present valid and reliable data.

Table of Contents

Executive Summary

This report was developed in response to the membership of the Older Adult Service Providers of Calgary (OASPoC) observing that seniors with serious mental illnesses were often at risk of losing their housing. They also noticed that vulnerable individuals who were younger than the traditional "senior" cut-off age of 65 were also falling through the cracks, as they presented as functionally geriatric. This report was commissioned to provide an overview of effective collaborative practices between seniors housing providers and mental health service providers, including those within the healthcare system.

The need for this kind of collaboration is present today and will only grow over time as the seniors' population doubles over the next 25 to 30 years. In Calgary, there are currently an estimated 1,065 to 2,130 seniors who are living with persistent psychotic disorders, including schizophrenia and delusional disorder, while some 21,300 suffer from some form of mental illness. That number will steadily increase as the seniors' population increases.

The project was designed to provide an overview of what is currently available in Calgary for this population, as well as what is needed. It also scanned relevant programs in North America that could provide potential models for Calgary. The methodology comprised both key informant interviews from service providers as well as a literature review of relevant programs in existence, including characteristics and components of model programs, and an overview of toolkits or guides.

Although there are services for older adults living with mental illness in Calgary, there is no coordinated system in place to provide adequate wraparound services for these individuals to maintain the security of stable housing. Many providers feel they have a "piece of the pie" but that nobody has access to the entire pie. In particular, Alberta Health Services' psychogeriatric programs are not well integrated into community agency operations. The Seniors Collaborative Community Outreach Team (SCCOT), a pilot project just launched in the flood-affected East Village, is a promising practice in this regard. In contrast, Edmonton seems to provide more services for this population, with more coordination and better integration of services.

The interviews showed that many service providers provided insight into the three top gaps for this population, namely lack of adequate housing, lack of understanding of mental illness within senior-serving agencies, and lack of attention on this population. When asked about best practices, interviewees talked about the best approaches to service delivery (screening/identification, early intervention, case management, harm reduction, trained and qualified staff who know the resources, person-centred care (right care, right time, right person), diagnostic services, 24-7 service, cultural competency), best practices in systems (availability of mental health services, including psychiatric services, availability of behavioral supports, resources/program stability, packaged services (especially housing and support), age-appropriate housing, one-stop shopping, awareness and understanding of resources available and accessibility of what services and programs are available) and how best to work individually with seniors living with mental illness (person-centred, respectful, ethical, without judgment, listening, manage, not control, relationship building/trust, empathy, include individuals 50+ who are functionally geriatric, and wanting to understand mental health and mental illness in more depth.

The literature scan identified many effective practices from other jurisdictions. BC and Ontario in particular have model programs that are worth investigating further. Effective programs and characteristics of program that emerged are as follows:

- Behavioural supports framework
- Recovery/rehabilitation philosophy
- Integrated care model
- Person-centred care
- Psychogeriatric case management/ Integrated system case management
- Team-based/service learning
- Transitional housing for stabilization

A variety of toolkits and guides were also identified that may assist agencies in working with seniors living with mental illness. These were organized according to the following categories:

- Mental health challenges for staff and volunteers
- Delirium
- Depression
- Suicide prevention
- Clinical assessments
- Mental health promotion for culturally diverse seniors
- Behavioural supports
- Help with integrated/collaborative systems

Finally, recommendations for OASPoC to move forward with this project were provided, both over the short- and long-term.

Recommendations

Put simply it seems that mental health service providers have a lack of understanding of geriatric issues, services and resources, and seniors' housing providers have a lack of understanding of mental health issues, services and resources. The number one recommendation would be to close this gap.

The consultants also recognize and endorse the recommendations regarding seniors' mental health and housing made in the 2010 Seniors and Special Needs Housing report.[1]

Short-term

1. Seniors' mental health outreach services provided by the social services sector and AHS Geriatric Mental Health program need to connect and help integrate services.
2. Ensure all relevant agencies (including the SCCOT pilot project) are informed of the research.
3. OASPoC needs to strike a Working Group that needs to further refine the research and models found in this report in order to develop recommendations for a proposed model for a specific system for Calgary.

[1] Caresce Inc. and MK Strategy Group, Inc. *Seniors and Special Needs Housing in Calgary*. Calgary: The Seniors and Special Needs Housing Sector Advisory Committee, July 2010.

4. Organize an annual city-wide gathering of senior service providers, including housing providers, service providers, mental health housing and service providers and homelessness services to highlight and advocate for this population.

Long-term

1. Inform and learn more about a model of integrated care for this population, including a centralized intake and information service model.
2. Advocate for more housing for seniors with mental illness in Calgary, in particular:
    a. Transitional housing for seniors with mental health issues so that they could be stabilized after discharge from acute or sub-acute settings and before going into permanent housing.
    b. Accessible, affordable, supportive, permanent community housing programs that provide wraparound case management and onsite services for seniors living with mental illness.
    c. Explore innovative models of supportive housing for individuals with similar support needs across sectors living in common settings (e.g. Alice Bissett Place).
    d. Such housing needs to take into account a harm reduction perspective.
3. Provide more communication and education opportunities for older adult service providers about mental illness in order to increase awareness of services and resources available and facilitate coordination of services.
4. Advocate for more multi-disciplinary outreach teams/support for seniors with mental health issues in jeopardy of losing housing (e.g. SCCOT pilot project in East Village.)
5. Advocate to address disparity in geriatric mental health services between Edmonton and Calgary.
6. Advocate with the Alberta Government that it needs to recognize and invest in this population, possibly through the Seniors' Advisory Council of Alberta (SACA) or the local Health Advisory council.

1. Introduction

This project began as a result of discussions within the Older Adult Service Providers of Calgary (OASPoC) about mental illness within the senior population. Certain older adults with serious mental illness were observed to be cycling through the system, with their housing placed at risk because of this. Many were discharged from hospital only to be evicted from their housing, and then were caught in a cycle of moving between hospital discharge and shelter life. For the older adults with mental illness, temporary shelters are not suitable or appropriate housing options. OASPoC felt there must be models in other jurisdictions where older adults with mental illness were better supported and where their housing was more secure. In particular, there was a need to investigate effective models of collaboration between seniors' housing providers and mental health service providers.

As such, funding was sought from the Calgary Foundation and the Calgary Action Committee on Homelessness and Housing, and an RFP was issued. Dr. Sue McIntyre and Dr. Lee Tunstall were contracted to undertake this research, with the following deliverables:

- Literature review and report on effective practices on collaboration between affordable seniors' housing providers and mental health service providers for seniors and the functionally geriatric with mental health issues who could be potentially at risk of homelessness.
- An executive summary of the final report including recommendations on a collaborative service model based on effective practices and emerging trends to watch. These recommendations will be useful for the development of the guidelines in Phase 2 of the project.

2. Scope of Work

The first task of the consultants was to determine parameters around the population to be studied. As such, in consultation with the project steering committee, a discussion regarding what to include and what not to include took place, with the following results.

The problem that this project is designed to address is the senior (65+) or older adult (50+ who is functionally geriatric) who cycles in and out of affordable housing, emergency housing and the healthcare system due to mental illness. The key issue is how to adequately and safely house these older adults and stabilize them with community supports, and how to do this in a collaborative, efficient way.

The topics to include in the research project are the following:

- seniors' affordable, non-profit housing providers
- functionally geriatric (50+ chronically homeless, etc.)
- mental health providers, especially with expertise with seniors and the functionally geriatric
- focus on hard-to-house seniors with mental health conditions
- all levels of seniors' housing are to be considered (Independent Living; S1-S4 Supportive Living)
- dual diagnosis concerns (addiction and mental illness; dementia and mental illness) are to be considered
- specialized populations are also to be considered (Aboriginal, immigrant, racialized)
- gender should be a consideration
- ideally, effective practices with third-party evaluations will be prioritized

- different types of mental illness (hoarding, personality disorder, etc.)

Topics to be excluded are the following:

- dementia and Alzheimers are not a priority concern for this project, as it is hoped/expected that the healthcare system will be the lead organization for this condition
- mental health promotion programs and activities that target the broad base of seniors
- seniors and the functionally geriatric who live in their own homes[2]

3. Methodology

3.1 Phase 1 – Data collection

The goal of this project is to research and document effective practices on collaboration between affordable seniors' housing providers and mental health service providers for seniors and the functionally geriatric with mental health issues who could be potentially at risk of homelessness. The following sources were accessed:

- existing literature gathered by OASPoC
- relevant academic literature
- literature published by senior-serving and mental health organizations (grey literature), and
- government-published reports.

The search was not restricted to only North America. If programs were found (e.g. in Europe or Australia) these were also collected to be analyzed. Academic searches were conducted through online databases such as Academic Search Complete; JSTOR; Academic Onefile, etc. Internet searches were conducted using various keywords to locate and research collaborative programs in existence and guidelines for effective practice. Reports from the federal and provincial governments and agencies were also integrated. Also, grey literature[3] from non-profit organizations, both senior-serving and otherwise, were also consulted.

OASPoC Consultation – There could be considerable expertise and information already existing within the broad OASPoC membership. As such, an email was sent out describing the project and asking for ideas of programs and resources that should be consulted. This included information on international literature review of effective programs, effective practices and collaborative working projects. Also, any names of other people who might have further information was gathered.

Key Informant Interviews (KIIs) - A brief interview schedule was designed, and interviews completed with people involved in effective programs or in organizations that may have relevant information. Interviews were completed by phone or email. The KII's were selected, focused and precise and 36 interviews were conducted for this project.

[2] This exclusion was decided before the project began, but some of the recommendations and effective practices could be useful to this population as well. This population may be included in Phases 2 and 3 of this project.
[3] Informally published written material (such as reports) that may be difficult to identify via conventional channels such as published journals and monographs because it is not published commercially or is not widely accessible. It may nonetheless be an important source of information as it tends to be original and recent. The term "grey literature" is commonly used in library and information science.

3.2 Phase 2 – Data analysis

This is an iterative process that occurred concurrently with data collection. As data was collected, it was analyzed to bring out recurrent themes and key components of effective programs. Certain effective programs were profiled, especially if there is a third-party evaluation of the program. A bibliography of sources and websites has been maintained as part of the project.

As the themes became more concrete, recommendations emerged. Conceptual and structural possibilities for collaborative programming were developed and explained.

3.3 Phase 3 - Verification

After a draft report was completed, it was provided to the Steering Committee for comment and discussion. Feedback and edits were integrated and a final draft resulted. This final draft was presented to the wider OASPoC committee (in Power Point format) to ensure validation and verification of the findings.

4. The issue

Older adults with mental illness are as prevalent as those in the general population: approximately 20% including dementia but excluding delirium.[4] However, there are certain differences in diagnosis, assessment and treatment for older adults that have unintended consequences. One of those is that such illnesses can put their housing at risk. As housing is a key determinant of health, their quality of life is also at risk.

Much of the literature surrounding seniors' mental illness often revolves around the so-called 3Ds: delirium, dementia and depression. Delirium is a short-term cognitive condition, sometimes induced by medication. It is quite often misdiagnosed by busy physicians. Of course, seniors present with the same serious mental illnesses that occur within the general population: schizophrenia and other psychotic disorders, bipolar disorder and borderline personality disorder can all occur within the senior population, either as ongoing conditions or as conditions that present for the first time in older age. Anxiety is also a mental illness that is often missed or misdiagnosed in seniors. Additionally, seniors can also present with obsessive compulsive disorder, a sub-type of which is hoarding behaviour, which is becoming an increasing concern for service and housing providers.

The 2011 Alberta Addition and Mental Health Strategy explicitly mentioned seniors with complex needs (seniors with complex health needs and addiction and/or mental health challenges) as a priority population. It notes the following regarding high priority service gaps for this group:

> Identify and mitigate high priority service gaps, specifically **community-based, crisis, residential care** and day hospital services throughout the province that have a behavioural rehabilitation focus. Improve access to housing options with innovative and versatile environment design to mitigate challenging behaviour and optimize opportunities for people with complex needs to live successfully in a community setting.[5]

---

[4] Jeste, D., et al. Consensus statement on the upcoming crisis in geriatric mental health research agenda for the next two decades. *Archives of General Psychiatry*, 56 (1999): 849.

[5] *Creating Connections: Alberta's Addiction and Mental Health Strategy*. Edmonton: AHS and Government of Alberta, 2011.

Another consequence is that older adults with mental illness face a double stigma in society: both ageism and living with a mental illness.

As seniors age and are sometimes placed into long-term care facilities, the percentage with mental illness rises. US data estimates between 30% and 56% of assisted-living facility residents have a mental health problem.[6] In Canada, the estimate is from 44%[7] to a staggering 80% to 90%.[8]

Other prevalence rates as to types of mental illness further demonstrate the issue:

- Canadian men over 80 years of age have the highest suicide rates in Canada.[9]
- Anxiety disorders occur in 5 to 10% of seniors.[10] Anxiety is a silent mental health issue for seniors, as it often goes undiagnosed.
- Seniors usually are diagnosed with GAD (Generalized Anxiety Disorder) or specific phobias.[11]
- Between 1 and 2% of seniors are affected by persistent psychotic disorders, including schizophrenia and delusional disorder.[12]
- Less than 1% of seniors live with bipolar disorder.[13]
- Delirium is experienced by almost 50% of seniors admitted to acute care, which rises to 70% in Intensive Care Units.[14]
- Alcohol problems occur in 6 to 10% of seniors.[15]

---

[6] Bartels, S.J. Improving the system of care for older adults with mental illness in the United States. Findings and recommendations for the president's new freedom commission on mental health. *American Journal of Geriatric Psychiatry*, 11 (2003): 486-497.

[7] Canadian Coalition for Seniors' Mental Health (CCSMH), *National Guidelines for Seniors' Mental Health: The Assessment & Treatment of Depression*. (Toronto: CCSMH, 2006).

[8] *Out Of The Shadows At Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada* (Ottawa: Standing Senate Committee on Social Affairs, Science and Technology Printer, 2006) and CCSMH,. *National Guidelines for Seniors' Mental Health: The Assessment and Treatment of Mental Health Issues in Long Term Care Homes (Focus on Mood and Behaviour Symptoms)* (Toronto: CCSMH, 2006).

[9] *Quick Facts: Mental Illness and Addiction in Canada*. 3rd Edition. (Guelph, ON: Mood Disorder Society of Canada, 2009).

[10] Bryant C, Jackson H & Ames D. The prevalence of anxiety in older adults: Methodological issues and a review of the literature. *Journal of Affective Disorders*, 109, 3 (2008): 233-250.

[11] Cassidy K-L, Rector N. The Silent Geriatric Giant: Anxiety Disorders in Late Life. *Geriatrics and Aging*. 11, 3 (2008): 150-6.

[12] Schizophrenia Society of Canada. *Information for Service Providers: Schizophrenia and Substance Use* (Winnipeg, n.d.)
Retrieved from: http://www.schizophrenia.ca/docs/SSC_for_Service_Providers.pdf
CCSMH, *National Guidelines for Seniors' Mental Health: The Assessment & Treatment of Depression* (Toronto: CCSMH, 2006).

[14] http://www.viha.ca/mhas/resources/delirium/

[15] CAMH Healthy Aging Project, *Responding to Older Adults with Substance Use, Mental Health and Gambling Challenges: A Guide for Workers and Volunteers* (Toronto: Centre for Addiction and Mental Health, 2006).

5. Trends to Watch

As the population numbers of seniors increase steadily over the next 20 to 30 years, there are a number of trends to watch that will impact the work of seniors' service providers.

1. As the seniors population increases, so will the number of seniors with mental illness. Unless systems are put in place now, there will be a crisis in how to deal with these individuals.
2. As we are providing better care to those living with mental illness and homeless individuals, these people are living longer and entering into the senior system of care.
3. These vulnerable individuals often age more quickly than others, and become "functionally geriatric" as early as 45 or 50.
4. Seniors sometimes develop mental illness later in life and this is often not diagnosed or misdiagnosed. Better assessments and screenings for seniors would help to better serve these individuals.
5. More diversity within the senior population will lead to the need for even more specialized services (e.g. ethno-cultural, Aboriginal, LGBT, etc.)

Special populations

If seniors with mental illness face at least a double stigma, some special populations have even more challenges to deal with than just this.

When it comes to gender, we know that currently senior women outlive senior men. We also know that women often self-report depression at higher rates than do senior men. Although both genders have a high suicide attempt rate, senior men over the age of 80 have the highest rate of suicide in Canada (31 per 100,000).[16] It is believed that suicide is vastly under-reported for both senior men and women due to its ongoing stigma.[17]

Homeless or at-risk of homeless seniors are at obvious and increased risk. Many providers agree that a chronically homeless lifestyle will age an individual up to 20 years more than their chronological age. This means that homeless seniors can be "functionally geriatric" by the age of 45. Many chronically homeless seniors also suffer from mental illness. The Greater Vancouver Regional District has reported that "approximately 50% were found to have two or more health conditions, including 53% with medical conditions, 45% physical disabilities, 31% with addictions, and 20% with mental health challenges."[18] In Calgary, the Drop-In Centre has reported that 3% of their guests are 65+, while those aged 46-65 represent 42% of all clients served. As we provide better and more comprehensive services for homeless individuals, more will age into the senior sector which will necessitate new ways of working.

---

[16] *Quick Facts: Mental Illness and Addiction in Canada* (Guelph, ON: Mood Disorder Society of Canada, 2009). Retrieved from: http://www.mooddisorderscanada.ca/documents/Media%20Room/Quick%20Facts%203rd%20Edition%20Eng%20Nov%2012%2009.pdf

[17] CCSMH, *National Guidelines for Seniors' Mental Health: The Assessment of Suicide Risk & Prevention of Suicide (*Toronto: CCSMH, 2006).

[18] Woolrich, R. and Gibson, N. Senior Homelessness in metro Vancouver: Strategies and Best Practices. *Seniors' Housing Update* 22, 3 (2013): 1.

Aboriginal seniors also face additional challenges, in particular those 55+ who attended residential schools.[19] These seniors have reported experiencing higher rates of depression than those who did not attend residential schools.[20] Although a smaller senior population, the Aboriginal senior population is expected to grow by 2017 to include 6.5% of the total Aboriginal population (8% of the Métis population; 6% of the First Nation population; and 4% of the Inuit population). [21]

Not much is known about the mental health of immigrant and ethno-cultural seniors. Mental illness is often a taboo subject within many immigrant populations and therefore is rarely discussed and rarely offered up for diagnosis and treatment. It often remains a hidden issue until it manifests in problems such as eviction from housing.[22]

[19] Health Council of Canada, *Canada's Most Vulnerable: Improving health care for First Nations, Inuit, and Métis seniors* (Toronto: HCC, 2013).
[20] Assembly of First Nations, *First Nations Regional Longitudinal Health Survey (RHS) 2002/03: Results for Adults, Youth and Children Living in First Nations Communities* (Ottawa: First Nations Centre, 2007).
[21] Turcotte, M. and Schellenberg, G.*, A Portrait of Seniors in Canada, 2006* (Ottawa: Minister of Industry, 2007).
[22] Sadavoy J, Meier, R and Ong, AYM. Barriers to access to mental health services for ethnic seniors: The Toronto study. *Canadian Journal of Psychiatry* 49, 3(2004): 192 – 199. Retrieved from: https://ww1.cpa-apc.org/Publications/Archives/CJP/2004/march/sadavoy.pdf

6. What We Know

6.1 The Calgary Situation

The 2011 civic census includes the most recent statistics we have for Calgary's senior population: 106,515.[23]

In a 2009 City of Calgary study where 354 seniors were surveyed along with 2,612 non-seniors, self-reported mental health of seniors was found to be better than that of non-seniors, in such categories as bereavement, being stressed, depressed, suicidal, being addicted to alcohol, drugs or gambling and lacking self-esteem. The only category seniors and non-seniors reported similar rates was for feeling lonely.[24]

There are some seniors in Calgary, however, who do suffer from mental illness, and it can have serious repercussions on their quality of life. If we extrapolate from the prevalence rates given above, the estimates for Calgary seniors living with mental illness is as follows:

- 20% with mental illness = 21,303
- 1 and 2% of seniors are affected by persistent psychotic disorders, including schizophrenia and delusional disorder = Between 1,065 and 2,130

Although this may not seem like a high number, bear in mind that the senior population is set to increase in Calgary to 166,000 by 2021 and will rise further to 20% of the city's total population by 2036.[25] As the senior population rises, the number of seniors with serious mental illness will also rise. Planning and preparations need to occur now before this projected increase becomes a reality.

6.2 AHS Geriatric Mental Health Program - Acute Care Services

Calgary has 20 dedicated acute care beds for seniors dealing with serious mental illness through the **AHS Geriatric Mental Health Program - Acute Care** located on Unit 48 at the Rockyview General Hospital. This unit serves all of southern Alberta and is therefore frequently operating at overcapacity. There are overcapacity beds available as well. The Department of Psychiatry 2013 Annual Report notes this, stating this situation warrants moving ahead with the previously proposed second geriatric psychiatry unit the Peter Lougheed Hospital.[26]

6.3 AHS Geriatric Mental Health Program - Community and Consulting Program

The AHS Geriatric Mental Health Program - Community and Consulting Team provides support to 29 long-term care facilities (one facility closed in the past year due to flooding), three transition units and

---

[23] City of Calgary, *2011 Civic Census Results* (Calgary: City Clerk's Election and Information Services, 2011). Retrieved from: http://www.calgary.ca/CA/city-clerks/Documents/Election-and-information-services/Civic-Census/2011_census_result_book.pdf. This is the most recent census that provides age-related data.

[24] Davis, L., et al., *Signposts II: Seniors Theme Report* (Calgary: City of Calgary and United Way, September 2012). Retrieved from: http://www.calgary.ca/CSPS/CNS/Documents/signposts/Sign%20Posts%20II%20-%20SENIORS%20Theme%20Report.pdf

[25] *Calgary's Aging Population: An Overview of the Changing and Aging Population in Calgary* (Calgary: City of Calgary, November 2011).

[26] B. Adams, Alberta Health Services, *Calgary Zone Clinical Department of Psychiatry 2013 Annual Report* (Calgary: University of Calgary, 2014). http://www.ucalgary.ca/psychiatry/files/psychiatry/2013%20AHS%20Psychiatry%20Annual%20Report.pdf

13 designated assisted living facilities within Calgary. The program employs 15 psychiatrists and 42 clinicians and dealt with over 2,000 referrals in 2013. One Registered Nurse position was recently added to the Seniors Community Collaborative Outreach Team (SCCOT) to support flood victims 55+. This is a pilot project located in the East Village. [27]

The Consulting Team has access to some of the clinicians, as well as access to a small specialized team for the more complex residents. This specialized team focus on education and support around non-pharmaceutical interventions.

There is also a mobile Behaviour Education Support team (BES) that supports staff teams working with seniors experiencing mental illness and complex behaviours. This team also has a role in transitioning these seniors with complex behaviours from acute care to the long-term care.

Services provided:

- assessment, treatment, outreach, and follow-up
- caregiver support
- one-to-one and group treatment for seniors with mood disorders, other long standing mental health conditions, and those with age-related dementia
- clinic and in-home service
- education for the client, caregiver, and community partners
- BES: education, mentorship, clinical support, and case consultation to long term care facilities and acute care transition units (ALC).

The family doctor and other caregivers are involved in the assessment and treatment plan. This service does not offer crisis intervention.[28]

The 2013 Annual report also noted the following areas of need:

• A dementia stabilization unit for patients with severe disruptive behaviours and a mental health long-term care unit have potential to reduce stress on acute care and improve patient outcomes.
• A second acute geriatric inpatient unit to accommodate the aging population.
• We continue to lack an outpatient geriatric psychiatry service.
• Subspecialty training program.
• Educator position to help build capacity in long-term care, additional staff to support geriatric addiction program and an occupational therapist position are needs in the community.

6.4 Transition Services

Carewest Glenmore Park currently operates the short-stay 20-bed sub-acute **Geriatric Mental Health Rehabilitation and Recovery Unit** in Calgary. This is designed for seniors (65+) who suffer from psychiatric disorders. They need to be stable and be responding to treatment, but also need some time

[27] B. Adams, Alberta Health Services, *Calgary Zone Clinical Department of Psychiatry 2013 Annual Report* (Calgary: University of Calgary, 2014)
http://www.ucalgary.ca/psychiatry/files/psychiatry/2013%20AHS%20Psychiatry%20Annual%20Report.pdf
[28] "Community Geriatric Mental Health Service" Alberta Health Services, 2014.
http://www.albertahealthservices.ca/services.asp?pid=service&rid=1602

to "settle". These seniors will have high psychosocial needs and they will likely benefit from rehabilitation services.[29]

The Canadian Mental Health Association and AHS operate **Hamilton House** (eight beds) and **Roberts House** (nine beds) Post Discharge Transition Programs for patients exiting acute care, but they are not focused on psychogeriatric issues and because of the low number of beds, there are waiting lists to access them.[30] The waiting lists are currently not that long (placement usually within three weeks) but although seniors are not excluded, not many use this service.[31]

6.5 Other AHS Services for Mental Health

AHS offers other services for individuals with mental health issues, and some other psychogeriatric mental health programs that do not include accommodation.

Access Mental Health

This is a telephone service (accessed through 403-943-1500, Extension 2, for adult and senior services) that provides information and telephone support about addiction and/or other mental health concerns. Clinicians help people navigate the addiction and mental health system. They are familiar with both AHS and community-based programs and will explore options and direct/refer clients to the most appropriate resource.

The ACT program (Assertive Community Treatment)

This program is not senior-specific but offers care to people with severe mental health problems or mental health problems who are not improving, who have trouble caring for themselves, accessing medical care, or getting help with legal, housing, or money concerns.
Services are offered in a person's home and may include:

- managing care
- giving and monitoring medicines
- helping access help with medical, dental, legal, financial or housing concerns
- involving family and community
- help with substance use problems
- teaching
- recreation groups

[29] "Geriatric Mental Health Rehabilitation Unit at Carewest Glenmore Park" Carewest, July 2010. http://www.carewest.ca/files/21.Geriatric-MH-Brochure-July-2010.pdf
[30] "Hamilton House and Roberts House Post Discharge Transition Programs" Canadian Mental Health Association Calgary, 2014.
https://calgary.cmha.ca/programs_services/hamilton-house-post-discharge-transition-program/
[31] Email discussion with Beth Gorchynski, AHS, April 22, 2014.

Geriatric Mental Health Day Treatment Program[32]

Although not dealing strictly with housing services, this AHS program provides timely access to short-term stabilization/treatment for seniors experiencing mental health symptoms of anxiety and/or depression. It may help to avert admission or reduce the length of stay on an inpatient unit, or may bridge transition back to community. This program operates out of the AHS Bridgeland Seniors' Health site.

Individuals participate collaboratively in a group-based, 10-week program designed to increase coping skills and enhance capacity to manage current and future mental health/psychiatric difficulties. Individuals work with a primary therapist and psychiatrist while attending a structured psycho-educational group program for two to three days a week. Treatment interventions include psycho-education, interpersonal therapy and community activation.

Criteria for inclusion in the program includes seniors living in Calgary with symptoms of depression and anxiety who agree to attend the 10-week, group-based program. They must also be cognitively able to participate in Geriatric Day Treatment programming. Referrals are done through Access Mental Health. There is currently about a two-month wait for acceptance into the program.[33]

Geriatric Mental Health Outreach Team[34]

The Geriatric Mental Health Outreach Team is a short-term, post-discharge, follow-up component of Unit 48 Acute Inpatient Service. Community nurses provide brief follow up, on a psychiatrist referral basis, to recently discharged psychogeriatric patients from Unit 48, other Rockyview General Hospital patients, as well as patients discharged from the Glenmore Carewest Mental Health Recovery and Rehabilitation Unit.

Services provided include brief case management (for approximately 90 days), to recently discharged psychogeriatric clients. Case management includes medications monitoring, community services brokerage, supportive counselling, caregiver support, and liaison with referring psychiatrists. Operating in compliance with the AIM standards of the Canadian Council on Health Services Accreditation, the Geriatric Mental Health Outreach Team primarily facilitates the transition of patients from hospital to community.

---

[32] C. Knight, *Maintaining Mental Health in the Community: Outcome Evaluation of a Geriatric Mental Health Day Treatment Service* (Calgary: AHS and Alberta Addiction and Mental Health Research Partnership Program, October 2012). Retrieved from: http://www.mentalhealthresearch.ca/KeyInitiatives/ResearchGrants/Seniors_PwD/Grants/Documents/FinalReports/Knight_-_CRGI_Ideas_Fund_Final_Report_(W).pdf; Personal communication with Alycia Berg, Intake Coordinator, May 27, 2014.

[33] Personal communication with Alycia Berg, Intake Coordinator, May 27, 2014.

[34] "Geriatric Mental Health Outreach Team - Rockyview General Hospital" Alberta Health Services, 2014. http://www.albertahealthservices.ca/services.asp?pid=saf&rid=1041907

Substance Abuse in Later Life (SAILL)[35]

The SAILL program provides a combination of treatment methods to assist seniors in the community who experience mental health issues and substance abuse difficulties.

Through a Harm Reduction model, the SAILL program assists seniors (60+) and their families with problems of alcohol and/or medication misuse. Services include assessment and treatment, case management, counselling (individual and family support), psycho-educational and alumni groups, social support luncheons, and medical consultation as needed. There is also the opportunity for all SAILL members to meet for the purpose of social connections and continued support. Potential clients can be excluded if they are living in long-term care, if their primary addiction is gambling or street drugs, or if they are cognitively unable to integrate information.

Short Stay Unit and Follow-Up Clinic-- Mental Health - Peter Lougheed Centre[36]

This service provides intensive psychiatric and psychosocial intervention, combined with active mobilization of community and family resources for those patients (not senior-specific) who have the potential to be cared for at a lower level of care within 72 hours. There is also a follow-up clinic that provides short-term support for people as they get ready to leave the hospital and access community programs and services.

Regional Capacity Assessment Team - Mental Health[37]

A service that provides mental health assessments to see if a person is able to understand information and use it to make personal decisions. Services provided include:

- assessing adults and older adults
- clinical consultations in the office, by telephone, or in the community
- giving presentations and training workshops

RCAT operates out of the Bridgeland Seniors Health Centre.

6.6 Supportive Housing

Older adults who suffer from serious mental illnesses and need access to specialized mental health housing often have challenges in Calgary. As there is no dedicated psychiatric hospital (like Alberta Hospital Edmonton in Edmonton) mental health supportive housing and services have been forced to be community-based in Calgary. In theory, this is the preferred philosophy. Unfortunately, community-based living and services are known to be under-funded when compared to demand, and therefore many individuals are left without appropriate housing or services.

There are also fewer mental health supportive living residences in Calgary, some of which do not serve senior residents. Additionally many seniors' housing agencies are finding that mental illness is becoming more prevalent in their independent living residences. AHS does fund a variety of supportive mental health housing options, but none of these programs is dedicated to seniors and the percentage of seniors accessing the programs is extremely small. These environments often do not take into account

[35] "AHS Substance Abuse in Later Life (SAILL)" Calgary and Area Addiction Services Guide, n.d. http://www.calgaryaddiction.com/pages/service-provider-information/ahs-substance-abuse-in-later-life-saill.php

[36] "Short Stay Unit -- Mental Health - Peter Lougheed Centre" Alberta Health Services, 2014 http://www.albertahealthservices.ca/services.asp?pid=saf&rid=1033757

[37] "Regional Capacity Assessment Team - Mental Health" Alberta Health Services, 2014. http://www.albertahealthservices.ca/facilities.asp?pid=saf&rid=1074654

the complex medical and mobility needs of seniors, and as the level of support is often quite minimal, seniors do not thrive in them. [38] For example, LAMDA (Community Living Alternatives for the Mentally Disabled Association) does not accept residents over the age of 65.[39] When people with mental health issues "age out" of the mental health housing sector, they "age in" to the senior housing sector. Unfortunately, this sector is not prepared for the multiple challenges associated with these seniors and do not have appropriate supports in place. Although many seniors' housing providers have gone beyond just a tenancy model and have introduced support services as residents' needs have changed and increased, the supportive residences for seniors in Calgary are often primarily designed for seniors living with dementia. However, seniors with significant mental health issues often do not manage well in these communities (SL4) and often wait longer for a bed. AHS also funds Personal Care Homes (SL3) where a significant number (approximately 60%) of individuals living in those homes have a mental health diagnosis, and the population is a mix of under and over 65. [40] Additionally, when mental illness emerges after 65 years of age when seniors are already living in an independent or supportive living community, it is often missed or misdiagnosed.

Currently, there is no dedicated seniors' residence for older adults with mental illness in Calgary. Up until February 2011, there was **Sunnyhill Wellness Centre,** [41] which provided a unique 38-suite residence where older adults, primarily with mental health diagnoses, were cared for under the Designated Assisted Living program.[42] It was located at the old Grace Women's Hospital, but closed when the owners decided not to renew a contract with AHS. All residents were moved to long-term care facilities, another designated assisted-living facility and a seniors' lodge at this time.

The only comparable seniors' residence in Calgary is currently Trinity Place Foundation's **Peter Coyle Place**. Peter Coyle Place provides an affordable accommodation option for hard-to-house seniors (55+). It provides supportive housing for those individuals who have exhausted all other housing options or have not been able to access typical seniors' housing in Calgary. Other Trinity Place residences are also home to some of this population. There is also a partnership in place with The Alex Seniors' Health Centre. However, this community does not focus solely on seniors with mental illness, although many do have mental and/or emotional issues.

Potential Place[43] also offers supportive housing for residents with mental illness in Calgary. They have 25 available apartments (nine in one building and 16 in the other) and people must be independent to reside there. Both houses are owned with no service provision caveats on them. There are currently two apartments designated for seniors, although 23% of their residents are between the ages of 55 and 65. Potential Place has a relationship (MOU) with CUPS, The Alex and Inn from the Cold for referrals. Many if not all of their clients come from their Club House Program. The addition of housing to the

[38] Email discussion with Beth Gorchynski, AHS, April 22, 2014.
[39] "LAMDA Referral Process" LAMDA, 2014. http://www.mylamda.com/referral.htm
[40] Email discussion with Beth Gorchynski, AHS, April 22, 2014.
[41] J. Komarnicki, All Sunnyhill residents moved to new homes, *Calgary Herald*, 26 May 2014. http://www2.canada.com/calgaryherald/news/city/story.html?id=ec5c29ee-2ace-4c64-823a-daf380e872d1
[42] Caresce Inc. and MK Strategy Group, Inc., *Seniors and Special Needs Housing in Calgary* (Calgary: The Seniors and Special Needs Housing Sector Advisory Committee, July 2010).
[43] Personal communication with Frank Kelton, Executive Director, April 1, 2014.

services in 2004 allows them to provide wraparound service to this population all who have varying degrees of mental health issues.

The Drop-In Centre also owns and operates **Bridgeland Manor**, a 49-unit building in Bridgeland that houses formerly homeless seniors and market renters. Supports are in place for seniors to transition to living in their own homes.[44] Bridgeland Manor is located in the inner city community of Bridgeland. It is a mixed market rent/affordable housing initiative that provides subsidized, supportive living programming with the goals of improving the quality of life and developing independence for homeless seniors. A Supportive Living Coordinator monitors the conditions of the apartments. This staff member takes note of maintenance issues that need to be addressed as well as offering decorating or design tips to residents when requested. There is a common room where residents can participate in life skills activities, such as cooking, cleaning and workshops are provided. Residents enjoy access to all Drop-In Centre services as well as assistance with meals, transportation, recreation and social activities, referrals to other service providers and assistance with medication.[45]

The **Bishop O'Byrne Housing for Seniors Association** also sets aside 14 of its 580 independent living suites for homeless seniors. Residents are referred to them by the Accessible Housing Society, Alpha House and the Alex. Wraparound services are provided to these residents and this is a process that is working well.[46]

Horizon Housing's Alice Bissett Place[47] is a 113-unit complex that provides affordable housing and support services (which are provided through the referring partners) for a diverse group of residents. The project was a partnership between **Horizon Housing Society** (the operator), CMHC and the Government of Alberta (capital funding), the City of Calgary (land and servicing), Calgary Homeless Foundation (funding), Calgary Home Builders Foundation (funding and project management), and Alberta Gaming (funding). The development includes a three-storey 103-unit apartment building with a five-bedroom apartment "pod" and 10 three-bedroom semi-detached townhouses. The apartment building's pod is for five brain injured tenants who will receive round-the-clock support from the Universal Rehabilitation Service Agency.

The diverse tenant group includes individuals with mental illness, brain injuries, physical disabilities, and low-income seniors and families. Referrals are made through St. Vincent de Paul Society for seniors. Inn from the Cold and Discovery House selects and refers families. Calgary Seniors Resource Society has access to 21 beds for seniors that are hard-to-house. Calgary Urban Project Society (CUPS) refers low income individuals. In addition, the Accessible Housing Society refers tenants with physical disabilities and Canadian Mental Health Association – Calgary Region refers people with mental illness.

---

[44] D. Lee, Bridgeland Manor, *Bridges* (Calgary: Bridgeland-Riverside Community Association, October 2013). http://brcacalgary.org/wp-content/uploads/sites/2/2013/10/Bridgeland-Oct-2013.pdf

[45] Personal communication with Isabel Ries Ferrari, Drop-In Centre Director, Education, Research and Best Practices on April 28, 2014.

[46] Personal communication with Myrt Butler, Chief Administrative Officer on April 28, 2014.

[47] City of Calgary, *Alice Bissett Place, Horizon Housing Society* (Calgary: City of Calgary, n.d.). http://www.calgary.ca/CS/OLSH/Documents/Affordable-housing/Alice-Bissett-Project-Profile.pdf?noredirect=1

The Kerby Centre for Older Adults also provides many services for older adults (55+) including a housing directory and a directory of services. **Kerby Rotary House**[48] is the first purpose-built shelter in North America for older adults experiencing elder abuse and homelessness. It offers safe, secure shelter to men or women over 55 years of age in Calgary and area, who are experiencing family abuse in their lives. These individuals can stay up to three months. The shelter provides crisis intervention, support, advocacy, referral, short-term housing and the necessities of daily life. In 2009, Kerby Centre began a partnership with Abri Seniors Housing. Six transitional beds were opened, which provide safe housing for older adults in unstable housing situations or facing homelessness. The goal is stable, independent living in the community. There is also a 24-hour crisis line - (403) 705-3250.

Calgary Alternative Support Services also operates **Langin Place**[49], however this is not senior specific and is only for males. Their focus is on supportive housing for single males experiencing mental health and/or addictions issues who have trouble maintaining housing. It is a housing project involving both Calgary Housing Company and Calgary Alternative Support Services. Langin Place provides tenants with affordable safe housing using the harm reduction model.

The lack of such a designated residence for older adults with mental health issues in Calgary is a significant gap in service.

6.7 Community Services - Seniors' Specific Mental Health

There is no one agency in Calgary that has seniors' mental health as their core mission in Calgary. There are also not many programs specifically designed for seniors with mental health issues in the community, but there are some agencies that work with seniors with mental illness.

The Alex Seniors' Health Clinic – This clinic is available to those 55+ who are in need of primary healthcare, who are low income and who are facing complex health and social needs. The clinic also provides services such as chronic disease management, smoking cessation, nutrition, pain management, and recreation therapy.

Seniors Collaborative Community Outreach Team (SCCOT) – This project is a collaboration between Trinity Place Foundation, The Alex, Calgary Family Services, the City of Calgary's Community and Neighbourhood Services and AHS and is focused on the East Village, where numerous seniors' housing residences are located. The focus of the project is provide person-centred care for seniors living in the area, which includes a mental health clinician. It is designed to provide "right amount of care at the right time and place to meet the unique needs of each client."[50] Its goal is to help seniors navigate the healthcare system, which can be complex and confusing, and to ensure they become permanently attached to the appropriate system supports.

[48] Kerby Rotary House, Kerby Centre for the 55+, 2014. http://kerbycentre.com/calgary-adult-services/shelter/
[49] "Langin Place" Calgary Alterative Support Services, 2012. http://www.c-a-s-s.org/programs/langin
[50] "Seniors Collaborative Community Outreach Team" The Alex, 2014. http://www.thealex.ca/programs-services/health/sccot-program/

6.8 Community Services – Seniors' Services with Mental Health Components

There are other agencies in Calgary that do not focus on seniors' mental health issues, but do come in contact with this population at times.

The Way In[51]

The Way In is provided by a network of four agencies: Calgary Chinese Elderly Citizen's Association, Calgary Family Services, Calgary Seniors Resource Society, and Jewish Family Services, and is funded by FCSS, City of Calgary.

The Way In's purpose is to enhance the quality of life of older adults 65 and over in their homes and neighbourhoods. The Way In team will help seniors or their loved ones connect with services and supports in their community including:

- preventing isolation (physical and social)
- information and referral services
- assistance with benefit applications and financial services
- short-term supportive counselling group work
- workshops

OWLS – Older Women Living Safely (Calgary Women's Emergency Shelter)[52]

The Calgary Women's Emergency Shelter's OWLS Program serves women, 50 years and older, who are currently experiencing family violence and abuse, or have left a relationship and are in crisis. Using a group process approach, clients are encouraged to tell their story, finding within these stories evidence of how they have resisted violence and abuse. Through a safe environment, women are encouraged to recognize their inherent strengths and resilience. The OWLS Program consists of two closed groups with approximately 8 to 10 women in each. The program is held weekly for 2 hours and consists of 36 weeks of group counselling spread over a one-year period.

6.9 Non-Senior-Specific Mental Health Services

There are also other services available for individuals living with mental illness.

PACT (Police and Crisis Team)[53]

This joint service from Calgary Police Service ad AHS offers help in crisis situations. It can arrange urgent psychiatry assessments and referrals as needed. This service is for people who:

- have a history of aggressive or violent behaviour
- have mental health issues or are in a crisis and have weapons
- have a history of drug or alcohol abuse and are likely to cause harm to themselves or others
- are very likely to be apprehended under the Mental Health Act of Alberta

---

[51] "The Way In - Calgary Older Adult Services, formerly known as Outreach Services" Third Age Commons, n.d. http://www.thirdagecommons.ca/news/way-calgary-older-adult-services-formerly-known-outreach-services

[52] "Community Services" Calgary Women's Emergency Shelter, 2014. https://www.calgarywomensshelter.com/programs/community-counselling-program

[53] "Vulnerable persons - Services and resources" Calgary Police Service, 2014. http://www.calgary.ca/cps/Pages/Community-programs-and-resources/Vulnerable-persons/Vulnerable-persons.aspx

MRT (Mobile Response Team)[54]

This is a joint service delivered by the Distress Centre and AHS. It is accessed through calling the Distress Centre and provides mobile mental health services, including:

- crisis intervention
- prevention
- urgent psychiatric assessments
- trauma response
- mental health education
- professional consultations

6.10 Comparison to Edmonton

Edmonton seniors with mental illness have considerably more options available to them than those in Calgary. **Villa Caritas,** operated by Covenant Health, opened in 2011 and is a 150-bed facility that serves seniors with complex mental health and medical needs. It provides both acute care and transition services. While 120 of these beds are designed to serve acute geriatric mental health patients (which includes the transfer of 106 beds from the geriatric psychiatry program from Alberta Hospital Edmonton), 30 of these beds are designated for seniors with mental illness who require specialized long-term care.[55] Villa Caritas is part of the Misericordia Community Hospital campus in west Edmonton. It is designed to provide "appropriate, timely intervention and care, with a focus on treating conditions and transferring seniors back home or to an appropriate care setting."[56]

There are also seniors' housing communities in Edmonton that have developed expertise in seniors with mental health issues. **Grace Manor**, operated by the Salvation Army, is a 100-suite community in north Edmonton for low-income seniors, many with mental illness, such as schizophrenia and bipolar disorder. It operates on the DAL specification of supportive living and is always at full capacity. There are plans for expanding the community, but none are firm as of yet.[57]

The other agency that houses seniors with mental illness is **Operation Friendship Seniors Society**. They operate a 40-bed **Rooming House** for hard-to-house seniors suffering from addiction, mental illness or both. There are clusters of four bedrooms sharing bathroom, kitchen and lounge areas, and this is co-located with the Drop-In Centre and Operations Friendship's offices. Rent is $450 per person.[58] There is no special staffing in this residence, just community outreach services.[59]

---

[54] "Mobile Response Team" Alberta Health Services, 2014. http://www.albertahealthservices.ca/services.asp?pid=service&rid=432

[55] Covenant Health, *Villa Caritas* (Edmonton: Covenant Health, n.d.) http://www.covenanthealth.ca/resources/Villa_Caritas_fact_sheet.pdf

[56] "Villa Caritas" Covenant Health, 2013. http://www.covenanthealth.ca/careers/edmontonopportunities/villa-caritas.html

[57] "History" Edmonton Grace Manor, n.d. http://www.edmontongracemanor.ca/index.html; "Grace in the Golden Years" Salvationist.ca, March 1, 2010. http://salvationist.ca/2010/03/divisional-spotlight-alberta-and-northern-territories/

[58] "Housing Registry/Facilities" Operation Friendship Seniors Society, 2014. http://www.ofss.org/housing-registry-facilities/

[59] Personal communication with Gail Sopkow, Executive Director, Operation Friendship, April 23, 2014.

Most recently, the **Greater Edmonton Foundation (GEF)**, a 3,100-suite management body with responsibility for affordable supportive and independent living, has launched **Ottewell Manor**,[60] a 38-unit apartment building strictly for seniors with mental illness. In this, they have partnered closely with AHS, who provides both direct services and training for GEF staff. This project has been so successful they are considering another similar building.[61]

6.11 Flood Impacts on Emergency/Transitional Housing

The June 2013 floods had a major impact on Calgary, and especially housing in Calgary. Rouleau Manor, a long-term care centre located in the Holy Cross Centre was closed, with a loss of 77 beds. Although all residents were moved into other care, this loss has stressed the system of long-term care, which has had a waterfall effect on other programs.[62] AHS has subsequently announced that the beds will be re-opened, although as of October 2014, it was still closed.[63] Other shelters have reported that they are at maximum capacity.[64] In effect, the floods created a crisis in housing in a city that was already experiencing a crisis in affordable and supportive housing for the city's most vulnerable individuals. As an example, the vacancy rate in Calgary was 1.2% in April of 2013[65]; it decreased to 1.0% in October 2013.[66]

One program to emerge in response to the floods is the **Seniors Collaborative Community Outreach Team (SCCOT)** initiative. See details of this project above.

Although this is a recent project, it is one that holds great promise as both the healthcare system and community services are working closely together.

6.12 Gaps in the System – OASPoC

The OASPoC Committee had also undertaken informal research to help identify gaps in the system that are letting down seniors with mental illness. The top seven responses were as follows (number of responses in parentheses):

- Services and supports for seniors with mental health and/or addictions issues (5)
- Lack of understanding about seniors mental health and addictions issues (4)
- Length of waitlists (4)
- Gap in services for older adults with complex needs between 50 – 64 years of age (4)

---

[60] *Support for older adults with addiction, mental health issues* (Edmonton: AHS and Greater Edmonton Foundation, October 17, 2012). http://www.albertahealthservices.ca/rls/ne-rls-2012-10-17-ottewell-manor.doc

[61] Personal communication with Raymond Swonek, Executive Director, GEF, April 23, 2014.

[62] J. Komarnicki, AHS called 'callous' for Holy Cross exit, *Calgary Herald*, August 29, 2013. http://www.calgaryherald.com/news/calgary/called+callous+Holy+Cross+exit/8844365/story.html

[63] "77-bed nursing home opening five months overdue as ER delays grow," *Calgary Herald*, October, 5, 2014. http://www2.canada.com/calgaryherald/iphone/news/latest/story.html?id=10264901

[64] The Drop-In Centre is reporting consistent occupancy rates of some 1,200 individuals per night during the 2013-14 winter. Personal communication with Debbie Newman, Executive Director, April, 2014.

[65] CMHC, *Rental Market Outlook- Alberta Highlights: Spring 2013* (Ottawa: CMHC, 2013). http://www.crra.ca/wp-content/uploads/2013/06/2013-Spring-Rental-Market-Highlights-for-Alberta.pdf

[66] CMHC, *Rental Market Outlook- Alberta Highlights: Fall 2013* (Ottawa: CMHC, 2013). http://www.cmhc-schl.gc.ca/odpub/esub/64371/64371_2013_A01.pdf?fr=1398552523893

- Lack of affordable housing (4)
- Lack of supportive housing (4)
- Lack of follow-up support (4)

Other responses included the poor response time to crisis situations, lack of agencies and/or housing which support seniors with both complex physical needs and mental health needs, lack of harm reduction housing for seniors and older adults and lack of coordination between service providers.

6.13 Costs

The 2010 report of the Seniors and Special Needs Housing Sector Advisory Committee included costs to the system of various interventions and services provided at different points of the healthcare system.[67] The table below summarizes these costs in Calgary as of 2010. It is more costly (with the exception of placement in long-term care) to support individuals waiting in the community than providing supportive housing in Levels 3 and 4.

Service	**Costs**
Home care client (average needs)	$10 per day (this varies greatly across a wide spectrum of client needs and corresponding services provided)
Waiting in community for Supportive Living Level 3 care	$86/day
Supportive Living Level 3 environment	$33/day
Waiting in community for placement in Supportive Living Level 4 or Long Term care	$160/day
Client in Supportive Living Level 4 environment	$92/day
Individual in Long Term care	$177/day
Geriatric Chronic Mental Health	$180/day
Geriatric Neurological Rehabilitation	$450/day
Cost to support a patient awaiting placement in hospital	$500/day

[67] Caresce Inc. and MK Strategy Group, Inc., *Seniors and Special Needs Housing in Calgary* (Calgary: The Seniors and Special Needs Housing Sector Advisory Committee, July 2010), 134.

7. What Others Know

7.1 Interviews

As part of this report, key informant interviews were conducted. A total of 47 agencies, services and names were identified. After review and discussion, five were excluded as they did not fit within the parameters of the interviewing population. This meant that a total of 42 agencies, services and names were to be contacted. All 42 were contacted. Thirty-six were interviewed which represents a response rate of 86%. The additional six were contacted and messages left twice. There were 11 questions asked of each person (see Appendix A for interview schedule and full data summary report and Appendix B for the list of agencies interviewed.) Highlights from these interviews are below, categorized according to questions asked.

Most Successful Programs

We asked what interviewees believe is the most successful program in existence for dealing with seniors with mental health issues and housing. Answers to this question fell into two main categories: collaborative and examples of individual agency work. The only example given of a collaborative approach was the SCCOT initiative. Individual agencies mentioned included: Kerby Centre, DOAP Team (Downtown Outreach Addictions Partnership – mentioned by Alpha House), the Alex's Pathways to Housing program, the Way In, LAMDA model (under 65 community living alternatives for mentally disabled), Silver's Memory Care program at the Beaverdam Community, the LOFT (Ontario) and Australia (behaviour support for Aboriginals), and Trinity Place Foundation (Peter Coyle, resources and people).

Three Best Practices

The next question asked about the three best practices in providing effective programming for seniors with mental health issues. The responses were focused around three particular themes: service approaches, systems and how best to work with the client. For service approaches the following were mentioned: screening/identification, early intervention, case management, harm reduction, trained and qualified staff who know the resources, person-centred care (right care, right time, right person), diagnostic services, 24-7 service, cultural competency. There was also concern about the best approach on how to deal with seniors with mental illness. These approaches were markedly person-centred and included such terms as respectful, ethical, without judgment, listening, manage, not control, relationship building/trust, and empathy. There was also a response to include individuals 50+ who are functionally geriatric, as well as a desire to understand mental health and mental illness in more depth. Finally, the systems best practices included such suggestions as: availability of mental health services, including psychiatric services, availability of behavioral supports, resources/program stability, packaged services (especially housing and support), age-appropriate housing, one-stop shopping, awareness and understanding of resources available and accessibility of what services and programs are available.

Gaps in Services

We then asked about the gaps in services (three greatest shortcomings) to provide effective housing programming for seniors with mental health issues. Interviews clearly discussed three main gaps that they saw within the system: lack of adequate housing, lack of understanding of mental illness within senior-serving agencies, and lack of attention on this population. Lack of adequate housing included such issues as wait lists, affordability and availability, family separation, homecare (availability and costs), and individuals living in unsupported environments. Lack of understanding of mental health

included not enough system knowledge or assessment ability, stigma about mental illness, and lack of knowledge on how to access mental illness services. There is also a lack of attention to this population, leading to undiagnosed or misdiagnosed disorders. Issues mentioned included no outreach, no funding, no trained staff or clinical staff, and late interventions. There were also issues mentioned, including the fact that AHS does not follow a harm reduction approach, too much red tape, too many siloes working independently, and a lack of cultural competency and translation for immigrant seniors with mental illness.

Missing Service Delivery Component

When asked about a missing service delivery component for senior with mental illness, responses centred around challenges with service providers, systems challenges and challenges for clients. For service providers, the challenges included: lack of expertise with seniors, translation expertise for seniors from different cultures, case management needed, harm reduction awareness programming, knowledgeably-trained teams in housing and support, wraparound services, and lack of outreach and internet information. Systems challenges included: limited services for 65+, piecemeal/ fragmented service, lack of adequate resources as population grows, lack of funding, seniors cycling through the system and many different agencies (passing the buck), lack of mental health services, difficulty in accessing psychological services, lack of expertise in gerontology, gaps and lack of social support, no advocates for this population, and lack of respect and regard for population. For clients, the missing delivery components were identified as: housing their relatives and being exploited as a result, lack of companion support, issues for those aged 50+ who are functionally geriatric (homeless, etc.) and transportation challenges (to get to resources, appointments, etc.)

Best Advice

When we asked them their best advice to deliver programs to this population, they responded with many ideas focused around training and awareness (both for staff and the general public), systems approaches, service approaches and viewing seniors with mental illness as a distinct population. Genuine, sincere and trained staff (including PTSD training) were suggested, as was work to combat the stigma and taboo of mental illness. Systems advice included: assisting seniors with system navigation, provide one-stop access to the system, address system gaps and barriers and provide sustainable funding and programs. Ways to improve service delivery included: early intervention, consistent action and follow-up, being client-driven, combine services and the right professionals, ensure community-based services/social services are connected (collaborative support programs), provide outreach services, be respectful and meaningful activities, address basic needs, design information sharing protocols to help complex cases and offer a broader menu of services and the way they are delivered. When viewing seniors with mental illness as a distinct population, their advice was: homeless people age much more quickly (more services to 50+), finding housing is difficult but it is even more difficult with the senior population, it is a diverse population, and the Housing First model has to be different for seniors. They wanted appropriate attention paid to this group.

Biggest Risk

The next question asked about the biggest risk. There were a variety of answers to this question, showing that there are many risks to this population that deserve attention. For service providers, they were worried that they will not work collectively or collaboratively, even though they know they should. There is also a lack of knowledge about this population, and they do not know how best to serve them.

They expressed a need to do environmental mapping to curtail service duplication, to avoid seniors not receiving the services they need which would result in poor quality of life. They also felt there was a risk that this population would be placed in institutions as opposed to community-based housing. Diversity was also mentioned as a risk, making sure to recognize it and ensure services are reflecting the community (e.g. First Nations, ethno-cultural seniors). They also saw many risks within systems, such as bed-blocking in hospitals waiting the right placement, seniors' mental illness not identified so that they become lost in the system, unpredictable, inconsistent funding, and the financial costs of running beds with wait lists. They feared that no one was watching this population so they are ignored and increasingly isolated. This population, and especially the seniors homeless population needs to be recognized as a distinct population. Finally, they are worried that if serious flooding occurs again, there will be no first response approach for seniors. Many also worried about risks to the clients themselves. Interviewees realized that seniors with mental illness face the double challenges of ageism and stigma, which can lead to isolation and fear of not being respected or believed. With rapid onset mental illness, they are at increased risk of eviction, and could move into unsafe housing situations. There is a risk that they do not open up about mental illness because of the stigma, and if they do they could lose family support. There was also a mention of the risk of physical violence and being robbed, as everyone knows when their cheque payments come in. At the very end of the spectrum of risk, there could accidents and deaths due to inadequate support. They wanted these seniors to never leave an agency unaware of what is available to help them.

Best Service Delivery Model

When asked about the best service delivery model, the interviewees talked about outreach and other examples, but they also spoke in general terms about the characteristics of good service delivery. Outreach was considered a good model, especially door-to-door, face-to-face, community-based outreach services, with visits every one to three days. Specific models mentioned included: services for persons with developmental disabilities (PDD), the Sharp Foundation (AIDS and HIV), the Move and Mingle fall prevention program, the Way In, SCCOT (Seniors Collaborative Community Outreach Team) and Neighborhood Houses (Vancouver and area). There was also mention of Independent Living Support (ILS) workers, and that Canadian Mental Health Association (Calgary) was beginning a seniors' program with ILS workers. The characteristics of the best service delivery model included: a focus on wellness/sustainability/assets, one-stop access to services, palliative and home care continuum, well-researched and client-centered, coordinated and strategic, inter- and multi-disciplinary, relationship-based, wraparound services, early interventions with more resources, better and more extensive housing, allowing the senior to live independently as long as possible and involving seniors in program development.

Who Should Lead?

Finally, we asked them who should lead services to this population. The most popular response was that it be a collaborative, multi-disciplinary approach that had collective impact. This should also include funders, such as the Calgary Homeless Foundation and government. Some responded that certain agencies in Calgary should take the lead, such as: The Way In, the Alex or CUPS and that it should be a local agency and not government. However, others felt that government should take the lead, such as AHS, the provincial government or even the municipal government.

7.2 Literature Scan

This literature scan took into account a program scan and relevant articles and grey material in the form of government non-profit reports and publications. Some relevant tools and guides that may be useful were also identified and are listed with brief descriptions in Section 8.

Themes around effective practices emerged as the literature review continued. The use of "effective" practices as opposed to "best" practices was preferred. Best practices can presume a hierarchy of programs and are often dependent on local situations or circumstances. What is ultimately desired is the identification of programs that are effective, and how they achieved this.

There has been a slow but growing awareness of seniors' mental health needs within the literature. In Canada, this work has been led by the Canadian Coalition for Seniors' Mental Health (CCSMH),[68] which was established in 2002. Their work to date has been focused on providing tools, guidelines and research on seniors' mental health issues through their National Guidelines for Seniors' Mental Health project.[69] The other organization that is active in this area is the National Initiative for Care of the Elderly (NICE),[70] which brings together researchers, practitioners, students and seniors dedicated to improving the care of older adults. They are focused on knowledge transfer and networking, with the purpose of connecting good research to practice. They also have produced a selection of pocket tools on the topics of ageism, caregiving, elder abuse, end-of-life, mental health, and financial literacy. The mental health pocket tools are on depression, hoarding, dual diagnosis with addiction and assessment of depression, delirium and dementia.

The Canadian Mental Health Commission also undertook research into seniors' mental health which resulted in *Guidelines for Comprehensive Mental Health Services for Older Adults in Canada* in 2011.[71] There are three sections to this report: Part 1 includes guiding values, principles, and recommendations about the determinants of mental health, mental health promotion and prevention; Part 2 includes a model for mental health services in later life, descriptions of the functions of each resource, and staffing benchmarks for specialized seniors' mental health services and early identification of mental health problems; Part 3 includes mechanisms that facilitate a comprehensive mental health service system (education, cultural safety, diversity, support for caregivers and service providers, and service delivery models.)[72]

---

[68] "Welcome" Canadian Coalition for Seniors' Mental Health, 2006. http://www.ccsmh.ca/en/default.cfm

[69] The guidelines include: *The Assessment and Treatment of Delirium, The Assessment and Treatment of Depression, The Assessment of Suicide Risk and Prevention of Suicide and The Assessment and Treatment of Mental Health Issues in Long Term Care Homes (Focus on Mood and Behaviour Symptoms).*All were published in 2006 and are available for download at: http://www.ccsmh.ca/en/natlGuidelines/initiative.cfm or in National Guidelines for Seniors' Mental Health. *The Canadian Journal of Geriatrics* 9, Supplement 2 (2006).

[70] "Who Are We?" National Initiative for the Care of the Elderly, n.d. http://www.nicenet.ca/

[71] MacCourt P., Wilson K., and Tourigny-Rivard, M-F, *Guidelines for Comprehensive Mental Health Services for Older Adults in Canad.* (Calgary: Mental Health Commission of Canada, 2011). Retrieved from: http://www.cmhawpg.mb.ca/documents/seniors-guidelines.pdf

[72] Ibid.

An adjunct to these guidelines is the *Seniors' Mental Health Policy Lens Toolkit*. [73] This document is designed to help policy makers and program designers determine the degree to which planned and current policies promote and support the mental health of seniors.

Behavioural Supports Framework

A philosophy of care that is emerging in Canada is the behavioural supports framework. It has a recent history in Alberta, but is much more established in Ontario. It focuses on the behaviour of the individual and its effects on family and caregivers, especially older adults with responsive behaviours stemming from mental illness, dementia or addiction. These responsive or challenging behaviours can take the form of aggression, wandering, physical resistance and agitation. Although predominantly developed with the imminent increase of dementia cases in mind, the framework includes seniors with serious mental illnesses that can often exhibit responsive behaviours. Behavioural Supports Ontario defines it as follows:

> to enhance services for older people with responsive behaviours linked to cognitive impairments, people at risk of the same, and their caregivers; providing them with the right care, at the right time and in the right place (at home, in long-term care or elsewhere).[74]

In Ontario, the Local Health Integration Networks (LHINs) have adopted behavioural supports as a key model and the Ontario government has invested $40 million to hire new staff-nurses, personal support workers and other health care providers, and to train them in the necessary specialized skills.

Behavioural Supports Framework - Principles

Person and caregiver-directed care is the overarching principle:

- Everyone is treated with respect and accepted "as one is"
- Person and caregiver/family/social supports are the driving partners in care decisions
- Respect and trust characterize relationships between staff and clients and care providers

Supporting principles bring these concepts to life for those making daily decisions about care:

- Behaviour is communication: Behaviours are an attempt to express distress, solve problems or communicate unmet needs. They can be minimized through interventions based on understanding the person and adapting the environment or care to satisfy the individual's needs.
- Diversity: Practices value the language, ethnicity, race, religion, gender, beliefs/traditions, and life experiences.
- Collaborative care: Accessible, comprehensive assessment/interventions include shared interdisciplinary plans of care that rely on input and direction from the client and family members.

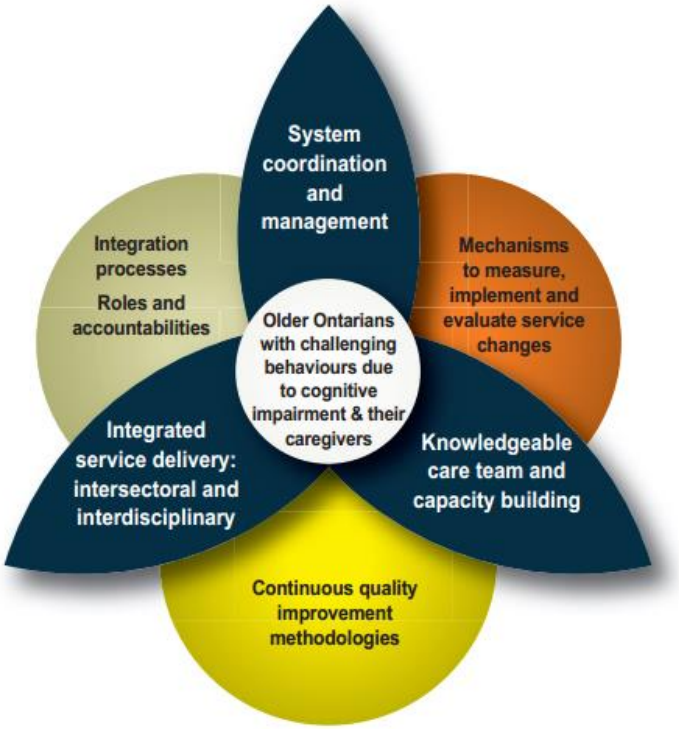
---

[73] MacCourt, P., *Promoting Seniors' Well-Being: A Seniors' Mental Health Policy Lens Toolkit* (Victoria, BC: British Columbia Psychogeriatric Association, 2008). Retrieved from: http://www.mentalhealthcommission.ca/English/system/files/private/Seniors_Seniors_Mental_Health_Policy_Lens_Toolkit_ENG_0.pdf

[74] "Behavioural Supports Ontario" Ontario's Local Health Integration Networks, 2006. http://www.lhins.on.ca/Page.aspx?id=1650

- Safety: A culture of safety and well-being is promoted where older adults and families live and visit and where staff work.
- System coordination and integration: Systems are built upon existing resources and initiatives.
- Partners to enable access to the range of needed, integrated services and supports.
- Accountability and sustainability: The accountability of the system, health and social service providers and funders to each other is defined and ensured.

The framework for care was also developed:



Source: *Ontario Behavioural Support Systems: A Framework for Care*.

In Alberta, the behavioural supports framework is being championed by the University of Alberta Faculty of Rehabilitation Medicine.[75] Its network of service providers, caregivers, policy and decision makers, researchers, and academics has just released *Advancing Behavioural Supports Alberta (BSA)*[76] which is the first step to developing a strategy and action plan for the province.

[75] "Behavioural Supports Alberta" University of Alberta Faculty of Rehabilitation Medicine, n.d. http://www.bsa.ualberta.ca/

[76] Brémault-Phillips, Suzette, *Advancing Behavioural Supports Alberta: A Secondary Data Analysis of the November 21st, 2012 Challenging/Responsive Behaviours Symposium - Developing an Alberta Action Plan* (Edmonton: Institute of Continuing Care Education and Research (ICCER), October 2013). Retrieved from: http://www.bsa.ualberta.ca/sites/default/files/CB_Symposium_report_FINAL_02-12-2013.pdf

Focus on recovery/rehabilitation philosophy

An overarching philosophy of working with individuals living with mental illness is recovery. This should not be understood as a cure philosophy, but rather that individuals can and should be able live a meaningful life in their community while achieving their full potential. Some seniors' groups have been uncomfortable adopting this model, especially when talking about dementia, as it is a degenerative condition. For seniors living with mental illness as opposed to dementia, the philosophy is a better fit. Outcomes including the reduction or elimination of symptoms and improved quality of life are possible with the right assessment and treatment.[77]

Integrated Care Model

Much of the literature surrounding this topic has to do with the concept of integrated care or integrated service delivery (ISD). Integrated care is also a key component of the behavioural supports framework. In this approach, the goals are to increase efficiency of services and improve continuity of care. This approach has been particularly targeted at the so-called frail elderly population, who present with multiple and complex health issues, including mental illness. Integrated care involves significant cross-sectoral collaboration, and although is the optimal method of service delivery, it is difficult to implement.

There is not much evidence-based research that surrounds model projects of integrated care, which could provide a basis for which model works best. MacAdam has documented the evaluated trials globally as of 2008.[78] Results included reductions in hospital and nursing home use, improvement in client satisfaction, and cost-effectiveness or cost savings. As it is, case studies and project descriptions provide the bulk of information available on these models.[79]

The Mental Health Commission of Canada (MHCC) *Guidelines* include a proposed model of integrated care for mental health service in later life (Figure 1). The complexity of such a model is obvious. Not only do sectors need to collaborate (health care, community agencies) but there needs to be collaboration *within* sectors (mental health and geriatric mental health; seniors' housing, seniors' services, mental health services, etc.)

The *Guidelines* also provide values and principles at both the individual and system levels.[80] Many of these reflect the comments heard during the interview stage.

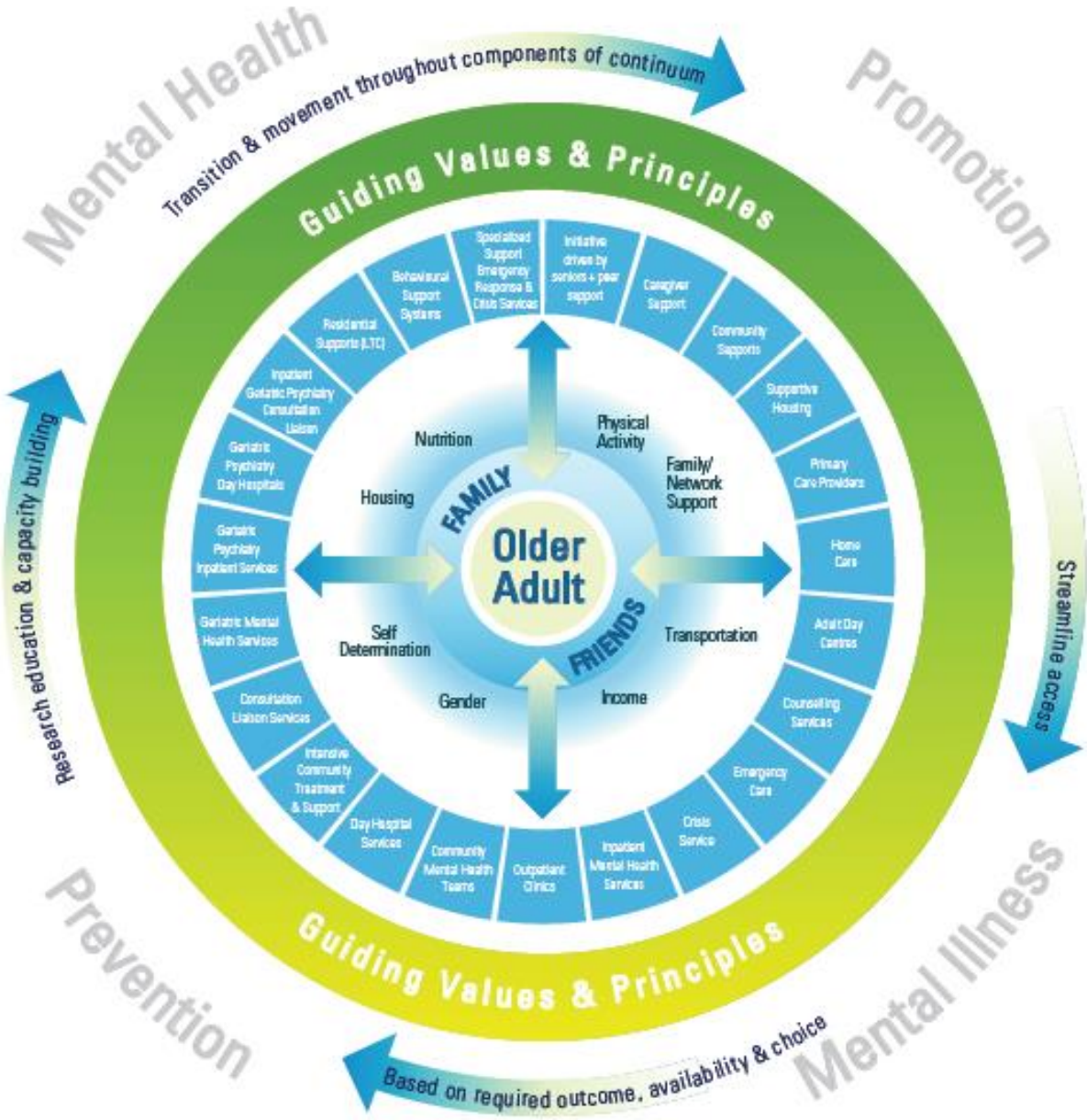
---

[77] MacCourt P., Wilson K., and Tourigny-Rivard, M-F., *Guidelines for Comprehensive Mental Health Services for Older Adults in Canada*. (Calgary: Mental Health Commission of Canada, 2011). Retrieved from: http://www.cmhawpg.mb.ca/documents/seniors-guidelines.pdf

[78] MacAdam, Margaret, *Frameworks of Integrated Care for the Elderly: A Systematic Review* (Ottawa: Canadian Policy Research Network, 2008). Retrieved from: http://www.cprn.org/documents/49813_EN.pdf

[79] Leichsenring, K., Developing integrated health and social care services for older persons in Europe *International Journal of Integrated Care* (2004).

[80] MHCC *Guidelines*, 27-29.


Mental Health
Promotion
Mental Illness
Prevention
Transition & movement throughout components of continuum
Guiding Values & Principles
Guiding Values & Principles
Research education & capacity building
Streamline access
Based on required outcome, availability & choice
Older Adult
FAMILY
FRIENDS
Nutrition
Physical Activity
Housing
Family/ Network Support
Self Determination
Transportation
Gender
Income
Specialized Support Emergency Response & Crisis Services
Initiative driven by seniors + peer support
Caregiver Support
Community Supports
Supportive Housing
Primary Care Providers
Home Care
Adult Day Centres
Counselling Services
Emergency Care
Crisis Service
Inpatient Mental Health Services
Outpatient Clinics
Community Mental Health Teams
Day Hospital Services
Intensive Community Treatment & Support
Consultation Liaison Services
Geriatric Mental Health Services
Geriatric Psychiatry Inpatient Services
Geriatric Psychiatry Day Hospitals
Inpatient Geriatric Psychiatry Consultation Liaison
Residential Supports (LTC)
Behavioural Support Systems

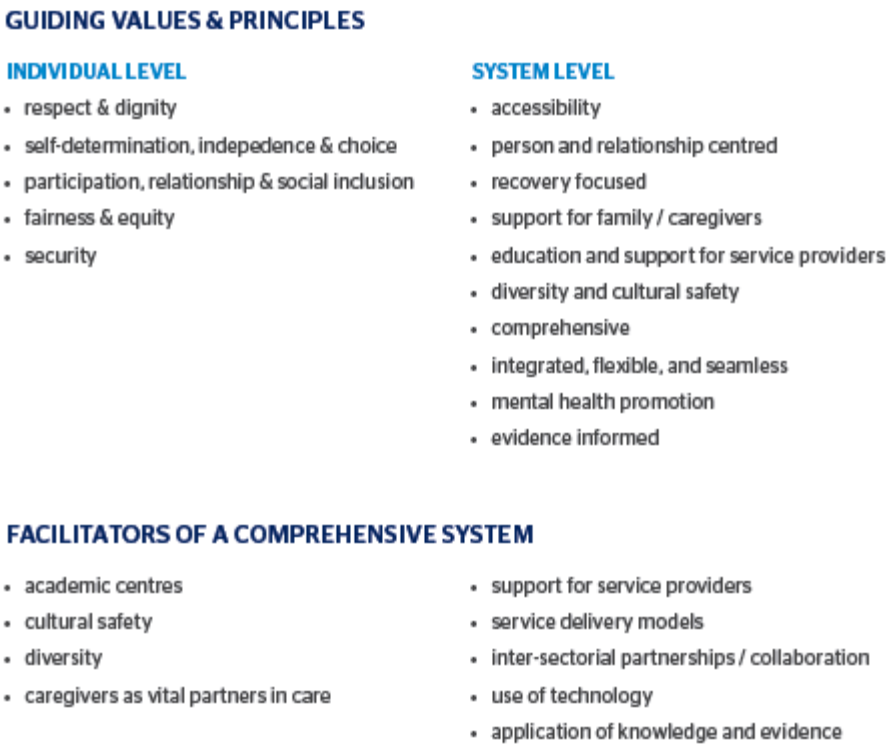


Figure 1: A Proposed Model of Integrated Care for Mental Health Service in Later Life[81]

As mentioned, this is a proposed and theoretical model. In practice, no model includes all of these factors working harmoniously together. Although listed within the model as a key component of community based service and programs, there are no insights given as to how supportive housing providers can better interface with the mental health system. The only advice given is as follows:

> Senior-friendly inpatient mental health services collaborate with community partners, ensuring effective discharge plans are coordinated to ensure a smooth transition back to the home setting (including supportive housing and long term care homes). General mental health services are appropriate for the majority of older adults who require an inpatient admission; specialized geriatric inpatient services should be reserved for a small minority of older adults who are experiencing extremely complex or severe mental disorders (Draper et al., 2006).[82]

For a different description of how systems can work together, Luetz gives a useful description of three levels of integration: linkage, coordination and full integration.[83]

[81] MHCC *Guidelines,* 49.
[82] MHCC *Guidelines*, 56.
[83] Leutz, WN. Five laws for integrating medical and social services: lesson from the United States and the United Kingdom *The Milbank Quarterly* 77, 1 (1999):77–110.

Linkage - health and social care providers attempt to work together more closely, but continue to function within their respective jurisdictions, eligibility criteria, funding constraints, service responsibilities, and operational rules;

Coordination - the rebalancing of the system through purpose-built structures and mechanisms to bridge gaps between services and users, and also help to address mandates and other areas that may not be clear, improve communication and improve the quantity and quality of the lack of information-sharing;

Full Integration - new, comprehensive programs are created to address the needs of medically and socially complex groups, by combining responsibilities, resources and financing from multiple systems under one organisational structure.

Luetz believed that full integration may not be the ideal for all circumstances, but that it would be effective for a "small subset of chronically ill patients that have unstable medical and functional conditions, [who] frequently interact with health and social care systems, and who require specialised interventions, expedited access to care, and close and ongoing collaboration between professionals."[84]

In the case of a sub-section of seniors that are dealing with serious mental illness, full integration would be the preferable model. Unfortunately, there is no common definition of integrated care in Canada, and it is considered an *elastic* term.[85]

Within Alberta, the Alberta Network of Senior-Related Organizations (ANSRO) has produced a white paper that puts forward a potential model of an integrated management strategy for seniors' supports, housing and care in December 2011.[86] A pilot project was planned from this white paper, and ANSRO was granted $100,000 for this purpose. ANSRO subsequently received $222,000 for Phase Two of the project, which was focused on field testing and evaluation in alignment with the Family Care Clinic system.[87]

Calgary Family Services Society has also been working with a model based on the Wilder Research Center's analysis of collaboration research.[88] It speaks to three levels of collaboration: cooperation, coordination and collaboration, with each level being a progressively integrated way to work together. Although not specifically designed for health care settings, the model may be useful as a starting point for groups wanting to enhance collaborative activities.

---

[84] Kodner, D. L. and Kyriacou, C.K., Fully integrated care for frail elderly: two American models *International Journal of Integrated Care* 8 (2000). Retrieved from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1533997/

[85] MacAdam, Margaret, *Frameworks of Integrated Care for the Elderly: A Systematic Review* (Ottawa: Canadian Policy Research Network, 2008). Retrieved from: http://www.cprn.org/documents/49813_EN.pdf

[86] Alberta Network of Senior-Related Organizations (ANSRO), *Supporting George and Betty: An Integrated Management Strategy for Seniors Supports, Housing and Care in Alberta* (Edmonton: ANSRO, December 2011). Retrieved from: http://www.ascha.com/PDF_files/rollout/2012/ANSRO%20White%20Paper%20December.pdf

[87] Alberta Network of Senior Related Organizations Integrated Services for Seniors Project, *Update to Supporters* (Edmonton: ANSRO, December 2013). http://www.ascha.com/PDF_files/rollout/2013/ISS%20Project%20Communique%20Dec%202013.pdf

[88] P.W. Mattessich, M. Murray-Close, B.R. Monsey, *A review of research literature on factors influencing collaboration* (St Paul, MN: Wilder Publishing Center, 2004).

Cooperation, Coordination, and Collaboration

A Table Describing the Elements of Each [1]

Essential Elements	Cooperation	Coordination	Collaboration
Vision and Relationships	• Basis for cooperation is usually between individuals but may be mandated by a third party	• Individual relationships are supported by the organizations they represent	• Commitment of the organizations and their leaders is fully behind their representatives
	• Organizational missions and goals are not taken into account	• Missions and goals of the individual organizations are reviewed for compatibility	• Common, new mission and goals are created
	• Interaction is on an as needed basis, may last indefinitely	• Interaction is usually around one specific project or task of definable length	• One or more projects are undertaken for longer-term results
Structure, Responsibilities, and Communication	• Relationships are informal; each organization functions separately	• Organizations involved take on needed roles, but function relatively independently of each other	• New organizational structure and/or clearly defined and interrelated roles that constitute a formal division of labor are created
	• No joint planning is required	• Some project-specific planning is required	• More comprehensive planning is required that includes developing joint strategies and measuring success in terms of impact on the needs of those served
	• Information is conveyed as needed	• Communication roles are established and definite channels are created for interaction	• Beyond communication roles and channels for interaction, many "levels" of communication are created as clear information is a keystone of success
Authority and Accountability	• Authority rests solely with individual organizations	• Authority rests with the individual organizations, but there is coordination among participants	• Authority is determined by the collaboration to balance ownership by the individual organizations with expediency to accomplish purpose
	• Leadership is unilateral and control is central	• Some sharing of leadership and control	• Leadership is dispersed, and control is shared and mutual
	• All authority and accountability rests with the individual organization which acts independently	• There is some shared risk, but most of the authority and accountability falls to the individual organizations	• Equal risk is shared by all organizations in the collaboration
Resources and Rewards	• Resources (staff time, dollars, and capabilities) are separate, serving the individual organization's needs	• Resources are acknowledged and can be made available to others for a specific project	• Resources are pooled or jointly secured for a longer-term effort that is managed by the collaborative structure
		• Rewards are mutually acknowledged	• Organizations share in the products; more is accomplished jointly than could have been individually

[1] Adapted from the works of Martin Blank, Sharon Kagan, Atelia Melaville, and Karen Ray.

Source: P.W. Mattessich, M. Murray-Close, B.R. Monsey, A review of research literature on factors influencing collaboration *(St Paul, MN: Wilder Publishing Center, 2004), p.61.*

Effective Program – Integrated Care – CHOICE (Edmonton)[89]

CHOICE is a Canadian version of PACE (Program of All-Inclusive Care for the Elderly), a US program centred around an adult day health centre.[90]

CHOICE provides services for older adults who have many health issues and are living in their own homes. Services include:

- access to a day centre
- checking and treating health issues
- filling prescriptions for medicines
- rehabilitation
- driving people to appointments
- 24/7 telephone support
- help with everyday activities

This service also offers special programs for people in the later stages of dementia or **who have long-term mental health issues.**

Eligibility:

For adults 60 years and older:

- with complex, long-term health issues who live in their own homes
- willing to change their family doctor and pharmacist to CHOICE healthcare providers
- can attend the day centre regularly using transportation provided

Under 60 years:

- functionally frail, physically disabled, cognitively impaired, or who have challenging behaviours

There are five service locations throughout Edmonton.

There is a Calgary equivalent of CHOICE operating at Carewest Sarcee called **Comprehensive Community Care Program (C3).** It provides integrated primary care consisting of different disciplines, such as nursing, occupational therapy, physical therapy, recreation therapy, social work, dietary, pharmacy, physicians and mental health consultants. C3 is available 24 hours a day, seven days a week. There is an emergency response team available to the clients when they are not open.[91]

[89] "CHOICE" Alberta Health Services, 2014.
http://www.albertahealthservices.ca/services.asp?pid=service&rid=1001469
[90] Kodner and Kyriacou, 13.
[91] T. Mendoza, Many hands come together for C3 clients*, Carewrite* (April 22 2010).
http://www.carewest.ca/files/70.2010-April.pdf

Effective Program – Program of research to Integrate Service for the Maintenance of Autonomy (PRISMA) - Quebec[92,93]

Designed for frail elderly and disabled populations, PRISMA focuses on improving continuity and increasing the efficacy and efficiency of services for this population. It is viewed as unique in that it includes all public, private or volunteer organizations that provide care and services to frail elders.

It accomplishes this by:

- co-ordination between decision-makers and managers
- a single entry point
- a case management process
- individualised service plans
- a single assessment instrument based on the clients' functional autonomy
- a computerized clinical chart for communicating between institutions for client monitoring purposes.

PRISMA is one of the few integrated care programs to have some formal evaluation completed. This has found the system to be effective in that fewer people in the program experienced a functional decline.[94]

What does an integrated model of care look like in practice? Kodner and Kyriacou provide a glimpse by providing an example case of a client in the PACE program.[95]

> *On enrolment in PACE, Mr. P. undergoes a comprehensive in-home assessment by the primary care physician, nurse and social work members of the team using a combination of DataPACE and other assessment tools. This process includes a complete medical history and physical examination. In addition to the diabetes reported by Mr. P., it is discovered that he has high cholesterol, and his diabetes has been poorly managed. He also experiences difficulty in performing all of his activities of daily living, as well as shopping and preparing meals, and he rarely leaves his flat. The primary care physician is especially concerned about Mr. P.'s deteriorating diabetes condition. He begins an aggressive course of treatment, which leads to a diagnosis of peripheral vascular disease. Until a full, interdisciplinary care plan can be completed, Mr. P. is provided with temporary, around-the-clock home care, and is transported to the adult day health centre five days a week, starting the next day.*
>
> *The results of the comprehensive assessment are summarised and presented to the entire interdisciplinary team at the next regularly scheduled meeting. After much discussion, the*

[92] Hébert, R. et al., Frail Elderly Patients: New Model for Integrated Service Delivery, *Canadian Family Physician* 49 (2003): 992-97.
[93] Hébert, R. et al., PRISMA: a new model of integrated service delivery for the frail older people in Canada, *International Journal of Integrated Care* 3 (2003): 1-8
[94] Hébert, R. Tourigny, A., Gagnon, M., *Integrated service delivery to ensure persons' functional autonomy* (Saint-Hyacinthe, Quebec: Edisem, 2005). Retrieved from: http://www.prismaquebec.ca/documents/document/Prisma_English.pdf
[95] Kodner and Kyriacou, 14-15.

interim care plan is accepted by the team, but with a few adjustments: Mr. P. will attend the adult day health centre for three days a week, instead of five as initially ordered. While at the centre, he will receive his daily insulin injection (because he is incapable of self-administration), and the nursing staff will monitor his medications. He will also see his primary care physician and a chiropodist on an on-going basis, and receive needed physical therapy. In addition, he will be served breakfast and lunch (both prepared under the supervision of a nutritionist), and participate in socialisation and recreation activities. This will be supplemented by 6 hours of in-home personal care assistance weekdays (including 2 hours in the morning before attending the centre), and 12 hours of home care daily on weekends. A home health nurse will visit Mr. P. on Saturdays and Sundays to help with his insulin. The program will also provide Mr. P. with a walker, and arrange for the installation of handrails in his flat.

The transportation worker arrives at Mr. P.'s flat one day to collect him for the adult day health centre. He discovers that the personal care aide is having trouble getting the patient ready. The aide complains that Mr. P. is somewhat lethargic. During the trip to the centre, the transportation worker notices that Mr. P. seems confused. Upon arrival at the centre, the worker reports these problems to Mr. P.'s nurse manager. The nurse manager detects a rapid pulse and abnormally low blood pressure. Concerned about possible hyperglycemia, she asks the on-call primary care physician to examine the patient. Hyperglycemia is confirmed, and Mr. P. is admitted to a nearby hospital for emergency care. The team is immediately notified about the admission.

While in the hospital, Mr. P. is treated by his regular primary care physician. After his glucose level is brought under control, he is then discharged to 12 hours of home care per day. Following a period of convalescence, he returns to his routine at the adult day health centre. There, Mr. P. will continue to be managed by the team, who will carefully monitor his progress, and will work together to ensure appropriate care.

Although an integrated model of care is the gold standard, it is rarely ever attained in its fullest form. There are components and characteristics of this model that can be selected ad hoc to create a customized model for seniors with mental illness in Calgary.

Person-centred care

One of the most important components of this integrated model and the behavioural supports framework is the concept or philosophy of person-centred care. This places the senior at the centre of the care that surrounds him or her, rather than the disease or disorder that they have. It "tries to focus on the interface between independent housing and care (''transmural care''), inter-sectoral joint working and the development of service-networks to guarantee older persons' participation in society. Thus, the approach goes far beyond acute health care models."[96] It also takes into account the

[96] Leichsenring, K., Developing integrated health and social care services for older persons in Europe, *International Journal of Integrated Care* (2004). Retrieved from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1393267/

environmental context that the person lives within: their family, marriage, culture, ethnicity and gender.[97]

Characteristics of person-centred care can include:

- In-depth knowledge of the person
- Inclusion of family and/or significant others in care
- Individualized communication
- Meaningful occupation/activity
- Supportive individualized environments
- Active involvement in community[98]

This approach is also rooted in a psychosocial model of care, as opposed to a bio-medical or managed care model. It also provides better outcomes for seniors at a lower cost.[99]

Effective Program - Older Adult Rehabilitation – St Joseph's Care Group, Thunder Bay, ON[100]

Older Adult Rehabilitation is a 25-bed male and female inpatient specialized mental health program for individuals over the age of 65 with severe, persistent mental health problems which may be associated with acute behavioral changes. These services are delivered in a collaborative, client-centered individualized manner to promote best practices principles and psychosocial rehabilitation philosophy.

This service is ideally suited for individuals over the age of 65 with a chronic or relapsing mental health problem who may require longer term rehabilitation before transitioning to a safe community setting. Other individuals 65+ may also have acute behavioral changes associated with mental health problems and will require a short-term hospitalization for assessment and stabilization in order to return to community living. These individuals will benefit from psychosocial and recovery focused care in a hospital setting. The primary goal is to promote living successful, satisfying lives in the community.

Services provided include treatment, stabilization, and transitional support. They are provided by skilled clinical professionals who work to facilitate clients' recovery, including: psychiatry, medicine, nursing, psychology, occupational therapy, social work, leisure lifeskills instructors, physiotherapy, spiritual care and dietary. Psychiatric rehabilitation interventions focus on the development of client skills and development of environmental supports for clients to return safely to community living.

---

[97] LeClair, K., Hedges, J. and Abbott-MacNeil, D., *PCTBSL: Person-Centred Team-Based Service-Learning* (Toronto: Behavioural Supports Ontario, March 2012). Retrieved from: http://www.bsa.ualberta.ca/sites/default/files/PCTBSL%20-%20Final%20March%2028_rev3July2012.pdf

[98] Thornton, L., Person-centred dementia care: An essential component of ethical nursing care, *Canadian Nursing Home* 22, 3 (2011): 10-14.

[99] LeClair et al., 10.

[100] "Mental Health Rehabilitation Programs" St. Joseph's Care Group, 2014. http://www.sjcg.net/services/mental-health_addictions/rehab/older-adult.aspx

Psychogeriatric Case Management/ Integrated system case management

One of the most important components of an integrated care model is psychogeriatric case management. Ideally, a psychogeriatric case manager would be a member of a network of integrated, community-based clinical services and supports for seniors with severe and persistent mental illness. These seniors would be frequent users of Emergency Departments and inpatient services. The case manager would provide client-centered assessments, treatment, rehabilitation and support services.

Within this role, the case manager would have as a key responsibility liaison and maintaining relationships with mental health providers, physicians, specialists and community workers who also would interface with the senior. This person should have a background in gerontology, or at least significant experience working with seniors. They should understand key philosophies of working with seniors.

Psychogeriatric case management is closely associated with integrated case management. Integrated case management is supported by effective system navigation and information-sharing processes to enhance service delivery. These services can include client-centred housing, and addiction and mental health services. Again, a key characteristic of integrated case management is to develop links to and relationships with primary health care services. It implements multi-disciplinary outreach teams focused on supporting people where they live and works to address key client issues, such as income support, housing options, and basic needs.[101]

Effective program – LOFT's Dunn/Spencer Project – Toronto, ON[102]

LOFT is a Toronto-based non-profit with a more than 50-year history serving vulnerable populations. They have been providing services to vulnerable seniors for more than 30 years. These are vulnerable and at-risk seniors with complex challenges including mental or physical health issues, addictions, behavioural challenges, dementia, absence of family support, social isolation, cultural dislocation and poverty.

One of their programs is the Dunn/Spencer project, which deals specifically with supportive housing for seniors with dementia or mental illness. LOFT works with Toronto Community Housing in two of their buildings in South Parkdale. LOFT provides residents with permanent housing and support in the buildings, with clients numbering around 37. They are male, female and transgendered and are usually 60+, but exceptions will be made for people needing the housing and services if they are 55+. Many are complex cases, with multiple physical conditions present as well. They are referred from the hospital system and other healthcare providers, Toronto Community Housing, and other community agencies. Some of the residents have spent up to seven years in a hospital setting.

LOFT adopts a three-part treatment approach to these seniors: personal support; psychogeriatric case management and social and recreational activities. Personal support services are available 24 hours a

---

[101] *Creating Connections: Alberta's Addiction and Mental Health Strategy* (Edmonton: AHS and Government of Alberta, 2011).

[102] Egervari, M. and Shin, W., *Supportive Housing Services for Seniors with Mental Illness and the Stepping Stone Project* (Toronto: LOFT, January 25, 2011). PowerPoint presentation.

day, seven days a week, while case management works on more regular business hours, but available 24/7 as a resource to on-site staff.

This program has been effective in that in it costs $30/day per client – much less than a long-term care home or a hospital setting. The clients report feeling safe and connected, but it is acknowledged that this trust builds over time. The project is also "built on the back of existing programs."

It is successful for many reasons. First, it is person-centred, uses a recovery model, and works towards goals set by the clients themselves. It focuses on client strengths as opposed to their weaknesses. Staff are properly trained and there are sufficient of them. Finally, they work to build partnerships with both the health care system (who provide the clinical supports) and community agencies.

The challenges identified included having enough capacity to provide quality service. There is also much effort taken to create and maintain the clinical and community partnerships, known as the "external team". Stigma was mentioned, as were difficulties working with other housing providers and having to develop non-traditional staff roles. To overcome these challenges, networking, community education, increased staff training, and open and ongoing communication with housing providers were put in place. In essence, the program is always seeking creative solutions and always puts the client first.

Team-based/Service Learning

This is part of an approach associated with the behavioural supports framework that is known as Person-Centred Team-Based Service-Learning (PCTBSL). As the person-centred approach has been dealt with above, team-based and service learning will be explained here.[103]

Team-based learning and care can be defined as:

> Collaborative networks of individuals who put the needs of the person and family at the centre of care. Interprofessional communication and trans-professional care are required to meet the needs of individuals who have complex health care challenges. Team based learning brings multiple perspectives and may help to maintain a standard of care that is holistic, person-centred and effective.[104]

Closely related to team-based learning is service-learning, where the learning site is at the setting of service delivery rather than a traditional classroom. It is different from other approaches as there is a reflective component that may become a catalyst for social change. The objective is to have healthcare professionals learn together through their relationships with each other. They can combine content knowledge, situational experience, team collaboration and exchange and active reflection.[105]

---

[103] LeClair, K., Hedges, J. and Abbott-MacNeil, D., *PCTBSL: Person-Centred Team-Based Service-Learning* (Toronto: Behavioural Supports Ontario, March 2012). Retrieved from: http://www.bsa.ualberta.ca/sites/default/files/PCTBSL%20-%20Final%20March%2028_rev3July2012.pdf

[104] LeClair et al.

[105] LeClair et al.

Staff – Training and Flexibility[106]

These two models of learning speak to the need to increase training for staff in new methods of working with seniors with mental illness. There also needs to be flexibility of staffing roles and schedules, so that the staff can work more effectively with this population.

Effective Program - Psychogeriatric Resource Consultants (Ontario) [107]

In Ontario, they have developed a role of Psychogeriatric Resource Consultants (PRC). They are active in in long-term care homes, community care access centres and other health care settings. Their role is primary role is to educate, advise and support staff in the application and interpretation of assessment tools for care planning and treatment for persons with cognitive/mental health needs and associated behavioural issues. In essence, they are professional trainers for people working on the front lines with older adults with mental illness. They work out of community mental health centres, geriatric facilities and Alzheimer Society chapter offices across the province.

Effective Program – Cool-Aid Society's FairWay Woods Supportive Housing for At-Risk of or Homeless Seniors – Victoria, BC[108]

The Cool-Aid Society runs this supportive housing residence for homeless seniors, which was the subject of an in-depth case study produced by the CMHC in 2007.[109] FairWay Woods is a 32-suite apartment building that is located in suburban Langford, BC. It operates on a harm reduction approach.

There is staff onsite 24 hours/day, seven days per week. The tenants are usually 75% male, and the median age of residents is 55 to 64 years old, which is understandable considering it is acknowledged that being homeless prematurely ages an individual. They came from various prior living arrangements including a detoxification facility, a hospital, other Cool Aid housing projects, shelters and substandard housing. The majority are facing complex medical conditions, both physical and mental. The turnover at FairWay Woods is low.

The staffing model at FairWay Woods is very flexible. There are two types of employees who work at FairWay Woods – Community Health Care (CHC) workers paid for by the health care system and Cool-Aid employees. Care was taken to ensure that the Community Health Care workers would only work at FairWay Woods and would work full shifts, so that trust could be built up with the residents. They work

---

[106] *Mental Health and Addictions Issues for Older Adults: Opening the Doors to a Strategic Framework* (Toronto: Canadian Mental Health Association Ontario. March 2010). Retrieved from: http://ontario.cmha.ca/download.php?docid=433

[107] "Psychogeriatric Resource Consultants" Alzheimer Knowledge Exchange Resource Centre, n.d. http://www.akeresourcecentre.org/PRCs

[108] "Fairway Woods" Victoria Cool-Aid Society, n.d. http://coolaid.org/our-services/homes/supportive-housing/fairway-woods/

[109] Canada Mortgage and Housing Corporation (CMHC), *Supportive Housing for Homeless and Hard-to-House Seniors: An In-depth Case Study,* Socio-economic Series 07-017 (Ottawa: CMHC, September 2007). Retrieved from: ftp://ftp.cmhc-schl.gc.ca/chic-ccdh/Research_Reports-Rapports_de_recherche/eng_unilingual/Housing_Homeless_HH_Seniors(w).pdf

with residents inside their suites and help with personal care (e.g. cleaning, meal preparation, personal care and laundry) and hazard reduction (e.g removing rotten food, watching for electrical cord problems, etc.) All of these CHCs were mature males. The Cool-Aid staff were chosen for their flexibility and experience, not necessarily for their formal credentials. They first and foremost would have to show respect towards the residents, and not view them as inferior. It was felt that ideally staff members should be "mature adults with considerable life experience."

The interaction of the two types of workers is key to success. They must work together as a team and share information. They themselves say the important point is the ability to be flexible but firm. Each employee also realizes they have different relationships with each resident, and call on each other to help if necessary. They also characterize their best working styles as providing services in a flexible, casual manner, with a team spirit, a willingness to "help out", and at times that "fit in with the tenants' routines".[110]

Cool-Aid's Street Angel

Another key staff member in the development of the FairWay Woods project was "The Street Angel". This individual was hired for two years and was focused on identifying and learning about the needs, characteristics, priorities and housing preferences of homeless and hard-to-house older adults who had multiple health problems. There were three key outcomes of this preparatory work:

- Housing and service providers who were supporting the idea were able to learn more specifics about their potential tenants or clients.
- Cool-Aid became familiar with their potential tenants on a personal level, and was therefore able to effectively screen them.
- Cool-Aid created a list of identifiable, potential tenants in need of supportive housing. This list made the need for the proposed housing project more compelling and real and was instrumental in getting support from different agencies.[111]

Transitional Housing for Stabilization

When older adults who have needed acute treatment for mental illness in a hospital setting are ready for discharge, there few options. Sometimes, their housing has been put at risk or they have been evicted and they cycle in and out of various crisis shelters and back to hospital. Calgary has a sub-acute facility for seniors, but there are only 20 beds available. What is needed is a form of transitional supportive housing that can allow seniors to stabilize enough to be able to return to the community.

[110] CMHC (2007), 28
[111] CMHC (2007), 37-38.

Effective Strategy – LOFT's Stepping Stone Project – Toronto, ON[112, 113]

This project is located at LOFT's John Gibson House Supportive Housing residence. It is a partnership between LOFT, the Centre for Addiction and Mental Health (CAMH) and the Toronto Local Health Integrated Network (LHIN). The target group to serve is seniors 60+ with serious mental health and addictions challenges who are referred from CAMH and from acute care or hospitals. These are the "frequent flyers" of the health care system and have been institutionalized on a long term basis and have a long history of not complying with treatments. Many have been rejected by long-term care and have few housing options in the community. They have known homelessness and social isolation all too well.

There are 12 suites (rooms are shared by two people) at John Gibson House that are dedicated to the Stepping Stone Project. These clients are supported by one transitional housing worker and one coordinator, who is a social worker. There is also 24-hour support provided by personal support workers, as well as onsite crisis intervention, if required. Initial assessment are completed in partnership with CAMH and residents have access to social, recreational and rehab services located at John Gibson House.

CAMH provides access to their psychogeriatric outreach team (PACE), which includes Registered Nursing care, a geriatric psychiatrist, and an occupational therapist on a consultation basis. Clients are visited two to three times per week and there is onsite crisis intervention as well as follow-up services.

This project operates on a tenancy basis, and clients sign tenancy agreements that clearly state it a transitional housing only. Rent is geared to income.

Admission criteria:

- Seniors 60+ who have significant mental health and/or addiction challenges
- **Presently** psychogeriatric patients in CAMH or a general hospital within the Toronto Central LHIN boundaries
- Seniors who are assessed (by OT) as being able to eventually live independently in the community with appropriate supports
- Seniors who are assessed as **NOT** requiring long-term nursing home care
- Must voluntarily agree to the program and services
- Admission includes the hospital signing a "Take Back" agreement

Exclusions:

- Cannot function in their daily lives without special medical equipment such as continuous IV, oxygen, etc.
- Seniors assessed as requiring nursing home care

[112] "Seniors Mental Health Supportive Housing" LOFT, n.d. http://www.loftcs.org/programs/supports-for-seniors/john-gibson-house/

[113] Egervari, M. and Shin, W., *Supportive Housing Services for Seniors with Mental Illness and the Stepping Stone Project* (Toronto: LOFT, January 25, 2011). PowerPoint presentation.

- Seniors needing 24-hour nursing and medical/psychiatric on-site support
- Seniors who are very violent and are likely to cause harm to themselves and/or others
- Recent history of fire/arson, sexual abuse, physical violence, and/or unsafe smoking

Reasons for discharge:

- The client requires an additional level of professional services that LOFT is not qualified to provide or is unable to access through other available resources
- The client is assessed to require long-term nursing home care
- The client is no longer able to direct their own care to live independently
- The client no longer wishes to continue to receive services
- The client a risk to themselves and/or others and the situation remains unresolved after attempts to address it

The project has had significant success. From its inception in February until January 2011, 65 individuals were admitted, 35 with a primary diagnosis of schizophrenia and eight with schizoaffective disorder. Of these 65, 42 have moved on to permanent lower supportive housing in the community. Many have recovered their activities of daily living (ADL) skills and are building linkages and relationships in the community.[114]

7.3 Examples of Other Supportive Housing Programs for Older Adults with Mental Illness

SHIP (Supportive Housing in Peel) - Ontario

SHIP is a non-profit supportive housing agency located in Mississauga, Ontario. Although they provide many types of supportive housing to many different target populations, they have two particular programs that target seniors with complex medical and mental health conditions.

Integrated Seniors' Team (IST) Program[115]

The program is a unique partnership between SHIP, Peel Senior Link and Punjabi Community Health Services. Seniors 55+ can access the program, which is designed to maximize the ability of high risk seniors to live independently in their homes. The IST is comprised of community counsellors, community mental health counsellors, personal support workers and case managers. They provide risk management assessment and education, personal support services and access to supportive housing options. They are active in North West Brampton, where they make in-home visits. Other services include: 24-hour on call system for emerging crisis situations, in-home visits addressing social, educational, physical fitness and mind stimulation needs, chronic disease prevention and management through linkages with existing community-based health programs, and fall prevention training, assessment and management of environmental and home risk factors.

[114] LOFT has also conducted qualitative research on their seniors' supportive living programs. It is available in a PowerPoint presentation format at: www.ccsmh.ca/ppt/A4b.pps

[115] "Integrated Seniors Team Project" Supportive Housing in Peel, 2009. http://shipshey.ca/en/content/integrated-seniors-team-program

Residential Multi-Service Teams - seniors[116]

This program works with tenants who are living in SHIP housing. Its goals are to assist clients with setting and working towards recovery goals, and living independently in the community. There is a seniors' program embedded within the RTSTs, and the mental health counsellors in this program work with individuals who are 55 years of age or older (exceptions due to accelerated aging are considered), who have been diagnosed with a serious mental illness, who require case management support for living, learning and/or working; and are willing and ready to work collaboratively with CMHC.

Hillside Terrace – Cool Aid Society – Victoria, BC[117]

Hillside Terrace is a 45-unit, Assisted Living project for seniors 55 and older, built in partnership with BC Housing and the Island Health (VIHA). Hillside Terrace provides housing to seniors who have difficulty fitting into regular housing situations and need a higher level of care. Residents are provided two meals per day, daily home support and weekly housekeeping services.

Staff at Hillside Terrace are trained to handle problematic behaviours that are sometimes associated with a history of homelessness, addictions and/or mental health issues, which allows us to create a more tolerant environment than usual.

LOFT Seniors' Supportive Housing – Toronto, ON

Beyond the LOFT's Dunn/Spencer Project and Stepping Stones Project explained above, the organization also operates other supportive living residence for seniors living with mental illness.

Behavioural Support Services – Mobile Support Teams[118]

One of LOFT's newest seniors' programs, this is part of the wider Behavioural Support Ontario implementation. LOFT has three unique mobile support teams that provide a timely and knowledgeable response and enhance the health care services of seniors, their families and caregivers, who live and cope with responsive behaviours associated with dementia, mental illness, addictions and other neurological conditions. They provide services when they are required and wherever they live, at home, in long-term care or elsewhere.

The goal of the BSS-MST is to respond in a timely manner, to advise family and caregivers, provide referrals to appropriate services, enable clients to keep their housing and prevent unnecessary hospitalizations.

LOFT operates three teams supporting older adults and their caregivers living within the geographical boundaries served by the Central Local Health Integration Network, or Central LHIN. This area includes South Simcoe, York Region and the northern part of Toronto.

---

[116] "Residential Multi-Service Teams (RMST)" Supportive Housing in Peel, 2009. http://shipshey.ca/en/content/residential-multi-service-teams-rmst

[117] "Hillside Terrace Referral Process" Victoria Cool-Aid Society, n.d. http://coolaid.org/hillside-terrace-referral-process/

[118] "Timely Response for Seniors Experiencing Behavioural Challenges" LOFT, n.d. http://www.loftcs.org/programs/supports-for-seniors/behavioural-support-services/#sthash.3tUgbh2Y.dpuf

Specialized Community Re-integration Program - Crosslinks Seniors Housing and Support Services - Transitional Housing[119]

Similar to the Stepping Stones project, eight transitional housing units are dedicated to working with seniors living with serious mental illness or addiction issues. Their partner in this project is Humber River Regional Hospital and approximately 25 individuals are housed annually. The goal is to move them on to either community housing or another of LOFT's supportive living programs for seniors.

Crosslinks Seniors Housing and Support Services

Crosslinks operates in two large Toronto Community Housing Corporation apartment buildings. It includes 130 affordable seniors' apartments and provides services to 250 clients a year. All of LOFT's support services (personal support; psychogeriatric case management and social and recreational activities) are available to residents.

John Gibson House[120]

This LOFT supportive housing program focuses on specialized high-support housing to vulnerable and at-risk older adults and seniors. This program provides permanent and transitional housing and support services for men and women aged 55+ with mental health, addiction and housing issues. This house is designed to divert at-risk seniors from nursing homes or homeless shelters. There is a full meal program plus all of LOFT's support services (personal support; psychogeriatric case management and social and recreational activities) are available to residents.

St Anne's Place[121]

St Anne's Place provides assisted living to older adults and seniors, age 59+ who are experiencing mental/physical health challenges, who are or have been homeless and require affordable and supportive housing. There are 110 suites and services include one meal per day (lunch), and support services 24 hours/seven days a week on individual basis as needed. These services include: assistance with personal care, meal preparation, essential housekeeping, laundry services, medication support, and escorts to appointments. Psychogeriatric case management services include assistance navigating the health care and social services systems, and in finding and accessing any services an individual resident may require. Social and recreation activities are also provided.

Bradford House

Located near downtown Bradford, Ontario, this residence provides supportive housing to 54 residents in single and double rooms. All of LOFT's support services (personal support; psychogeriatric case management and social and recreational activities) are available as well as a full meal plan and 24-hour onsite service.

---

[119] "Assisted Living for Vulnerable Seniors in the Jane & Finch Community" LOFT, n.d. http://www.loftcs.org/programs/supports-for-seniors/crosslinks-seniors-supportive-housing-services/

[120] "Seniors Mental Health Supportive Housing" LOFT, n.d. http://www.loftcs.org/programs/supports-for-seniors/john-gibson-house/

[121] "Supportive Apartment Building for At-Risk Seniors" LOFT, n.d. http://www.loftcs.org/programs/supports-for-seniors/st-annes-place/

College View Supportive Housing Services[122]

This supportive housing residence serves vulnerable seniors with complex medical and psychological issues, but this residence serves an ethno-culturally diverse group of 65 older adults and seniors living in a large Toronto Community Housing Corporation apartment building in downtown Toronto. A third of College View clients are Chinese. The Toronto Community Housing Corporation provides affordable housing, while LOFT provides the services.

Assisted Living Services for High-Risk Seniors - Government of Ontario[123]

Assisted Living Services for High-Risk Seniors is a program designed to assist frail or cognitively-impaired seniors who do not need 24-hour nursing care and can reside at home with support; however, their care requirements cannot be met solely on a scheduled visitation basis. This program provides a combination of personal support and homemaking services, security checks or reassurance services, and care coordination. Services are available around the clock, on a scheduled and as-needed basis.
Services are provided to clusters of clients in their own homes within a geographic service area designated by the Local Health Integration Network as a "hub", or to clusters of clients in apartment buildings. Clustering of clients provides an efficient and effective means to provide long-term care that helps to keep people independent and prevent/delay institutionalization. Staff providing services operate from a location in the centre of the "hub" which allows them to get to the client quickly in an emergency.

Australia - Management and Accommodation of Older People with Severe and Persistent Challenging Behaviours in Residential Care[124]

Australia has various models that align most closely with Canada's Behavioural Supports Framework. Various models within Australia are assessed in this report, including psychogeriatric nursing homes in Victoria, extended inpatient psychogeriatric services in Queensland, ADARDS nursing home in Tasmania, and high dependency units in Western Australia. Although this also has impacts for persons living with dementia, these models have relevance for older adults living with severe mental illness.
New South Wales has also developed a comprehensive plan for Specialist Mental Health Services for Older People (SMHSOP).[125] This includes a model of care for older people with 'severely and persistently challenging behaviours'. This model includes integrated specialist behavioural assessment and intervention services, special residential aged care service packages, interim specialist assessment and treatment facilities and an intensive care behavioural unit.

---

[122] "Support for Vulnerable Seniors in Toronto's Downtown Core" LOFT, n.d. http://www.loftcs.org/programs/supports-for-seniors/college-view-supportive-housing-services/

[123] "Home, Community and Residential Care Services" Ontario Ministry of Health and Long-term Care, 2008. http://www.health.gov.on.ca/en/public/programs/ltc/13_housing.aspx

[124] New South Wales Severe and Persistent Challenging Behaviours Project, *The Management and Accommodation of Older People with Severe and Persistent Challenging Behaviours in Residential Care* (Sydney: The Centre for Mental Health, NSW Department of Health, April 2004).

[125] Mental Health Drug and Alcohol Office, *NSW service plan for specialist mental health services for older people (SMHSOP) 2005-2015* (North Sydney, NSW: NSW Department of Health, 2006). Retrieved from: http://www0.health.nsw.gov.au/policies/gl/2006/pdf/GL2006_013.pdf

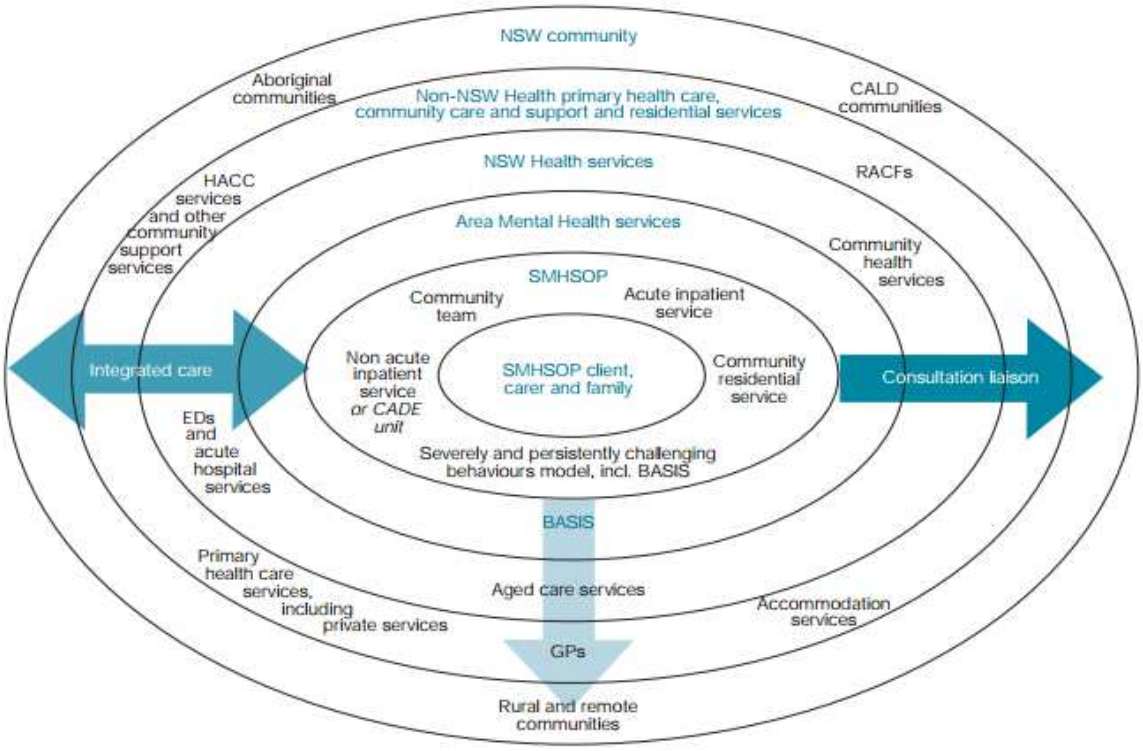


Figure 2: New South Wales proposed system of care and support for older people with mental health problems

8. Toolkits/Guides

There are numerous toolkits and guides that can be of assistance to seniors' housing providers when looking at dealing with seniors with mental illness. Some of the most common are found below.

8.1 Mental Health Challenges – Staff and Volunteers

Responding to Older Adults with Substance Use, Mental Health and Gambling Challenges: A Guide for Workers and Volunteers.

"This guide is designed for people who work with older adults in their homes, in the community and in long-term care. This includes personal support workers, health care aides, meals-on-wheels and friendly visitor volunteers, and staff at seniors' centres, residences, apartments and nursing homes. This booklet is also for people who supervise or educate first contact staff."

From: Centre for Addiction and Mental Health - Healthy Aging Project (Toronto), 2006.
Link to .pdf:
http://www.camhx.ca/Publications/Resources_for_Professionals/Older_Adults/responding_older_adults.pdf

*****

Tips and Techniques for Supporting Residents with Mental Illness: A Guide for Staff in Housing for Older Adults.

"This guide contains basic information about the most common mental illnesses; case studies; and tips, techniques and suggested language to help people manage complex behaviors and demanding situations. It is not intended to be all inclusive, nor should the guide be used as a substitute for seeking guidance or assistance from a mental health professional. This guide is written to address the mental health issues that often face residents in housing for older adults. It should be noted that this guide cannot address the specific mental health needs of the many cultures and language groups living in these communities. Beliefs and behaviors vary from culture to culture and this must always be considered when thinking about what is "normal " behavior and what may indicate a mental health issue."

From: Frankel, M., Freed, G and Isenberg, L. (Jewish Community Housing for the Elderly and Jewish Family & Children's Service, Boston, 2012.)

Link to .pdf:
http://www.jfcsboston.org/LinkClick.aspx?fileticket=5mk9jq%2BxWVU%3D&tabid=395&mid=1079

*****

Promoting Seniors' Well-Being: A Seniors' Mental Health Policy Lens Toolkit.

This toolkit has been designed to promote and support the mental health and well-being of all seniors. It is a set of questions to identify (or predict) any direct or indirect negative repercussions of policies, programs and services (in place or proposed), on seniors' mental health. It supports the development or analysis of any policy or program relevant to seniors, including those that do not directly target either mental health or seniors. Its implementation has been evaluated as a best practice in policy design to support seniors' mental health.

From: MacCourt, P., British Columbia Psychogeriatric Association, 2008.

Link to .pdf:
http://www.mentalhealthcommission.ca/English/system/files/private/Seniors_Seniors_Mental_Health_Policy_Lens_Toolkit_ENG_0.pdf

8.2 Delirium

Delirium in Older Adults: a guide for seniors and their families.

This user-friendly guide is designed to help older adults who are concerned about delirium. It will also help family members and other who care about them. The guide gives information about the causes and symptoms of delirium and how to prevent it. It also describes what to do if you, or someone you care about, is experiencing delirium.

From: Canadian Coalition for Seniors' Mental Health
Link to .pdf: www.ccsmh.ca/pdf/ccsmh_deliriumBooklet.pdf

8.3 Depression

Depression in Older Adults: a guide for seniors and their families.

This user-friendly guide will help older adults who are feeling depressed. It will also help family members and others who care about them. The guide gives information about the causes and symptoms of depression. It also describes what to do if you, or someone you care about, is feeling depressed.

From: Canadian Coalition for Seniors' Mental Health
Link to .pdf: www.ccsmh.ca/pdf/ccsmh_depressionBooklet.pdf

8.4 Suicide Prevention

Suicide Prevention among Older Adults: a guide for family members

This user-friendly guide was designed for family members and other people who provide social support to older adults, including friends, neighbours and community members. This guide will help you be able to recognize suicide risk factors and warning signs, and what you can do if an older adult in your life is at risk for suicide.

From: Canadian Coalition for Seniors' Mental Health
Link to .pdf: www.ccsmh.ca/pdf/ccsmh_suicideBooklet.pdf

8.5 Clinical Assessments

There are many assessment tools used to help detect mental illness within senior the population. Some need to be administered by trained professionals or clinicians, others can be self-reported or completed by a family member or caregiver. The US National Institute on Aging has a comprehensive list of assessment tools that they refer to as "instruments to detect cognitive impairment in older adults."[126] A sample of common tools follows:

Delirium: Assessment & Treatment for Older Adults (clinician pocket card)

Includes: Part 1 - Diagnosis, Prevention, Screening, Common Causes and Part 2 - Assessment and Management of Delirium in Older Adults.

From: Canadian Coalition for Seniors' Mental Health
Link to .pdf: http://www.ccsmh.ca/pdf/Delirium%20tool%20layout%20-%20FINAL.pdf

*****

Tool on Depression: Assessment & Treatment for Older Adults

From: National Initiative for the Care of the Elderly (NICE) and Canadian Coalition for Seniors' Mental Health
Link to .pdf: http://www.ccsmh.ca/pdf/CCSMH_depressionBrochure.pdf

[126] National Institute on Aging website: http://www.nia.nih.gov/research/cognitive-instrument/search?field_administration_metho_tid[]=3212

*****

Geriatric Depression Scale (GDS) – Short-form

The GDS Long Form is a brief, 30-item questionnaire in which participants are asked to respond by answering yes or no in reference to how they felt over the past week. A Short Form GDS consisting of 15 questions was developed in 1986.

From: Sheikh, J.I., & Yesavage, J.A. as cited by Sherry A. Greenberg, PhD(c), MSN, GNP-BC, Hartford Institute for Geriatric Nursing, NYU College of Nursing
Link to .pdf: http://consultgerirn.org/uploads/File/trythis/try_this_4.pdf
Links to GDS in other languages: http://www.stanford.edu/~yesavage/GDS.html
Link to iPhone app: http://www.stanford.edu/~yesavage/iPhone.htm
Link to Android app: http://www.stanford.edu/~yesavage/Android.htm

*****

Psychogeriatric Assessment Scales[127]

"The Psychogeriatric Assessment Scale (PAS) provides an assessment of the clinical changes of dementia and depression (Jorm et al, 1995). The package is easy to administer and score, and can be used by lay interviewers. It is intended for use both in research and service evaluation, taking about 10 minutes to administer by a trained lay interviewer or clinician. There are three scales derived from an interview with the subject (cognitive impairment, depression, stroke) and three derived from an interview with an informant (cognitive decline, behavioural change, stroke)."[128]

From: Jorm, MacKinnon, Henderson et al., 1995; Dementia Collaborative Research Centres (Australia)
Link to .pdf: http://www.dementia-assessment.com.au/cognitive/pas_scale.pdf

*****

Suicide: Assessment & Prevention for Older Adults (clinician pocket-card)

Includes: Part 1 – Risk Factors, Warning Signs and Symptoms and Part 2 – Assessment and Risk Management
From: Canadian Coalition for Seniors' Mental Health
Link to .pdf: http://www.ccsmh.ca/pdf/CCSMH_suicideBrochure.pdf

[127] Jorm, A., MacKinnon, A., Henderson, A. S., et al., Psychogeriatric Assessment Scales. A multidimensional alternative to categorical diagnosis of dementia and depression in the elderly,. *Psychological Medicine*, 25 (1995): 447 -460.
[128] Burns, A., Lawlor, B., Craig, S., Rating scales in old age psychiatry. *The British Journal of Psychiatry* 180 (2002): 161-167.

8.6 Mental Health Promotion for Culturally Diverse Seniors

Reach Up, Reach Out: Best Practices in Mental Health Promotion for Culturally-Diverse Seniors

This project was designed to increase capacity of community organizations to effectively respond to the mental health needs of culturally diverse older adults. These guidelines will also be of benefit to policy makers as they plan and develop services, programs, and policies that are culturally inclusive.

From: Victorian Order of Nurses (VON)
Link to .pdf: http://www.von.ca/en/special_projects/docs/RR_manual.pdf

8.7 Behavioural Supports

Capacity Building Decision Tree

From: Behavioural Supports Ontario
Link to .pdf:
http://www.akeresourcecentre.org/files/Behaviour/BSO_TheRoadAhead_TheRightToolattheRightTime_KP.pdf

*****

Capacity Building Roadmap

This guide is designed to assist Local Health Integration Networks (LHINs) and their local service providers build knowledgeable care teams who will provide the best care possible for older adults at risk of, or with complex healthcare challenges with responsive behaviours due to mental health, dementia, addictions or other neurological disorders, and their caregivers, in safe and supportive workplaces. This tool provides a framework for service providers to help organize their approach to training new staff and to align the first six months of training activities with the 12 core competencies.

From: Behavioural Supports Ontario
Link to .pdf:
http://www.akeresourcecentre.org/files/BSOResources/Capacity%20Building%20Roadmap%20Updated%20191212.pdf

8.8 Help with Integrated/Collaborative Systems

Person and Practice-Based Learning: Making a difference for older adults at risk or with complex health care challenges with Responsive behaviors through learning and development

This document provides an overview of the merits of using the Person and Practice-Based Learning framework as a driving methodology for achieving system transformation in the behavioural health sector through capacity enhancement activities associated with the Behavioural Supports Ontario (BSO) project.

From: Behavioural Supports Ontario
Link to .pdf: http://www.akeresourcecentre.org/files/PerPLe/PerPLeTool.pdf

*****

Person and Practice-Based Learning: Facilitator's Guide

The facilitator's guide is designed to assist LHINs to plan their learning, development and orientation activities for new hires related to the Behavioural Supports Ontario project. It will be helpful for Capacity Enhancement leaders (coordinators and educators) whose role is to plan initial training and ongoing sustainability learning experiences.

From: Behavioural Supports Ontario
Link to .pdf: http://www.akeresourcecentre.org/files/PerPLe/PerPLeTool_Facilitator%27s_Guide.pdf

*****

Complex Care Resolution for Older Adults with Responsive Behaviours

Includes: Definition of complex care, principles and recommended components to support complex case resolution.

From: Behavioural Supports Ontario
Link to .pdf: http://www.akeresourcecentre.org/files/Behaviour/Complex_%20Care_Resolution.pdf

*****

Establishing collaborative initiatives between mental health and primary care services for seniors. A companion to the CCMHI planning and implementation toolkit for health care providers and planners.

This is a guide is designed for providers wanting to establish or enhance the mental health services they provide through collaboration. This general toolkit offers readers a guide to all aspects of planning, implementing and evaluating a collaborative mental health care initiative, including assessing need, setting goals and objectives, developing a budget, building a team, maintaining a well-functioning team, managing change and monitoring the initiative.

From: Canadian Collaborative Mental Health Initiative (Mississauga, ON), 2006
Link to .pdf:
http://www.ccmhi.ca/en/products/toolkits/documents/EN_CompanionToolkitforSeniors.pdf

*****

Report Card – Client Centered Care: How are we doing?

Although designed for use in long-term care homes, this quick report card evaluates care and services, organization and staff.

From: Gina De Souza, Best Practice Coordinator Central South Ontario from Registered Nurses Association of Ontario.
Link to .pdf:
http://ltctoolkit.rnao.ca/sites/ltc/files/resources/CCCare/AssessTool/ReportCardSampleCCC.pdf

9. Recommendations

Put simply it seems that mental health service providers have a lack of understanding of geriatric issues, services and resources, and seniors' housing providers have a lack of understanding of mental health issues, services and resources. The number one recommendation would be to close this gap.

The consultants also recognize and endorse the recommendations regarding seniors' mental health and housing made in the 2010 Seniors and Special Needs Housing report.[129]

Short-term

1. Seniors' mental health outreach services provided by the social services sector and AHS Geriatric Mental Health program need to connect and help integrate services.
2. Ensure all relevant agencies (including the SCCOT pilot project) are informed of the research.
3. OASPoC needs to strike a Working Group that needs to further refine the research and models found in this report in order to develop recommendations for a proposed model for a specific system for Calgary.
4. Organize an annual city-wide gathering of senior service providers, including housing providers, service providers, mental health housing and service providers and homelessness services to highlight and advocate for this population.

Long-term

1. Inform and learn more about a model of integrated care for this population, including a centralized intake and information service model.
2. Advocate for more housing for seniors with mental illness in Calgary, in particular:
    a. Transitional housing for seniors with mental health issues so that they could be stabilized after discharge from acute or sub-acute settings and before going into permanent housing.
    b. Accessible, affordable, supportive, permanent community housing programs that provide wraparound case management and onsite services for seniors living with mental illness.
    c. Explore innovative models of supportive housing for individuals with similar support needs across sectors living in common settings (e.g. Alice Bissett Place).
    d. Such housing needs to take into account a harm reduction perspective.

[129] Caresce Inc. and MK Strategy Group, Inc. *Seniors and Special Needs Housing in Calgary*. Calgary: The Seniors and Special Needs Housing Sector Advisory Committee, July 2010.

3. Provide more communication and education opportunities for older adult service providers about mental illness in order to increase awareness of services and resources available and facilitate coordination of services.
4. Advocate for more multi-disciplinary outreach teams/support for seniors with mental health issues in jeopardy of losing housing (e.g. SCCOT pilot project in East Village.)
5. Advocate to address disparity in geriatric mental health services between Edmonton and Calgary.
6. Advocate with the Alberta Government that it needs to recognize and invest in this population, possibly through the Seniors' Advisory Council of Alberta (SACA) or the local Health Advisory Council.

10. Appendices

Appendix A - Data Summary - Interviews

Table of Contents

Introduction

The following report represents the findings from phone interviews for this project. A total of 47 agencies, services and names were identified. After review and discussion, five were excluded as they did not fit within the parameters of the interviewing population. This meant that a total of 42 agencies, services and names were to be contacted. All 42 were contacted. Thirty-six were interviewed which represents a response rate of 86%. The additional six were contacted and messages left twice.

The following represents the summary to the 11 questions responded to in the 36 interviews.

1) What work do you/your agency do in reference to seniors?

The responses to this question are as follows:

- Advocacy
- Alberta Health Services
- Basic Needs
- Calgary Police Services
- Counselling
- Detox
- Education
- Employment
- Elder Abuse Family Violence
- ESL
- Financial
- Food services
- Halfway House for Seniors (correctional housing that includes seniors)
- Homeless Programs
- Housing
- Information Services
- Mental Health Services
- Mobile Response Team
- Outreach
- Policy Work
- Recreation
- Research on Housing and Seniors
- Seniors Health Clinic
- Seniors Immigration Programs
- Seniors Support Programs
- Shelters (Homeless and Women's)
- Transportation
- Visitation/Support/Preventing Isolation
- Way In Team

2) What percentage of seniors do you believe are challenged by issues of mental health?

This answer to this question ranged from 5% to 85%. Some spoke of the isolation this population experiences which often prevents awareness and the accessibility of services. In discussion with immigrant service providers they spoke about the stigma that a mental health diagnosis or services will be tagged onto a family member which often prevents accessing support or services.

3) What percentage do you believe are at risk of homelessness?

The response to this question ranged from 5% to 100%. Obviously this varied by the service the organization provided. For example, in speaking with the Drop-In Centre the answer is 100%.

4) What do you believe is the most successful program in existence for dealing with seniors with mental health issues and housing?

The responses to this question are as follows:

Collaborative

- A continuum - no one program in particular
- Collaborative efforts
- Seniors Collaborative Community Outreach Team (SCCOT)

Individual agencies

- Kerby Centre
- DOAP Team (Downtown Outreach Addictions Partnership) - Alpha House
- Alex Pathways
- LAMDA model (under 65 community living alternatives for mentally disabled)
- Memory Care Silvera (Beaverdam Community)
- Ontario (The Loft) and Australia (behaviour support for Aboriginals)
- Trinity Place Foundation – Peter Coyle, resources and people

Other

- Subsidized housing for seniors
- Hospitals
- Don't know

5) What do you believe are the three best practices in providing effective programming for seniors with mental health issues?

The responses to this question are as follows:

Service approaches

- Screening/Identification
- Early intervention
- Case management
- Harm reduction

- Addiction services
- Outreach
- Purposeful activities and resources
- Multi-faceted programming (exercise, socialization, education and support)
- Group activities
- Client-focused, tailored programs
- Comprehensive services
- Positive programming giving hope
- PTSD services
- Nursing care
- Trained and qualified staff who know the resources
- Programs with back up and options
- The right care, the right time, the right person
- Follow through
- Client-focused
- In-home support
- Homecare flexibility
- Looking after physical needs
- Transportation
- Accessing legal capacity
- Diagnostic Services
- Visits
- 24-7 service
- Cultural competency
- Stabilization of clients
- Stability (of programs and staff)
- Motivational programs
- Transparent programs (know what to expect)

Approach to working with clients

- Respectful
- Ethical
- Without judgment
- Listening
- Manage, not control
- Relationship building/trust
- Connecting seniors to community/socialization
- Empathy
- Meaningful engagement
- Independence
- Understanding Mental Health
- Motivational

- Dealing with aging and isolation
- Include seniors in 50s, aged by life (functionally geriatric)

Systems

- Availability of mental health services, including psychiatric services
- Availability of behavioral supports
- Resources/program stability
- Package services, esp. housing and support
- Age-appropriate housing
- One-stop shopping
- Diversity of needs and services
- Awareness and understanding of resources available
- Accessibility of what services and programs are available

6) What do you believe are the three greatest shortcomings in providing effective housing programming for seniors with mental health issues?

The responses to this question are as follows:

Lack of adequate housing

- Waiting lists
- Affordability of housing
- Availability of housing
- Unhealthy, dirty places
- Unsupported environments
- Not having solid, reliable housing
- Lack Long-term Care
- Moving seniors away from family
- Family separation and isolation/not included
- In-house care (checking, food cleaning, etc.)
- Issue of homecare costs

Lack of understanding of mental health

- Knowledge of shut-ins and mental health
- Lack of mental health education
- Stigma about mental illness
- Lack system knowledge
- Lack assessment ability
- Lack awareness on how to access services

Lack of attention on this population

- Late intervention

- No support team
- Providing nothing
- Need to go to clients/outreach
- No staff orientation or training
- Lack of staff
- No clinical support
- No outreach
- Not enough funding
- Reliance on services such as DI

Other

- Red Tape
- Not sharing services--silos
- AHS lacks harm reduction approach
- Language barriers/lack translation services

7) Do you see a missing service delivery component not being provided or identified for seniors with mental health issues?

The responses to this question are as follows:

Service providers

- Lack expertise with seniors
- Translation expertise for seniors from different cultures
- Case Management for seniors needed
- Harm reduction awareness programming
- Knowledgeably-trained teams in housing and support
- Wraparound services
- Lack of outreach and internet information

Systems challenges

- Limited services for 65 plus
- Piecemeal/ fragmented no comprehensive service
- Adequate resources as population grows
- Lack funding
- Passing the buck
- Lack of mental health services
- Difficulty in accessing psychological services
- Lack of expertise in gerontology
- Gaps and lack of social support
- No advocates for this population/Lack of respect and regard for population
- Lack of dementia-friendly communities

Clients

- Housing relatives and being taken advantage of
- Lack of companion support
- Mental Health issues of 50+/functionally geriatric
- Transportation challenges

8) What is your best advice to deliver programs to this population?

The responses to this question are as follows:

Training/education - staff/general public

- Genuine and sincere staff
- Trained staff
- Address the taboo of mental health
- PTSD awareness and training
- Normal process not a stigma

Systems approaches

- Assist with system navigation
- One-stop shopping
- Address gaps and barriers
- Sustainable funding and programs

Distinct population

- Homeless people age much more quickly
- Housing difficult but even more difficult with senior population
- Diverse population
- Housing First model has to be different for seniors
- Pay attention to this group

Service approaches

- Early intervention before crisis builds
- Consistent action and follow through
- Community consultation but hear their voices
- Client-driven
- Combine services and professionals
- Community-based services/social service connection
- Outreach to the population
- Respect and meaningful activities
- Collaborative support programs
- Address basic needs

- Broader menu of services and way they are delivered

9) What is the biggest risk?

The responses to this question are as follows:

Service providers

- We won't work as collective
- Lack of knowledge about this population/Not knowing what we are dealing with/ age-related depression
- Need to do environmental mapping to curtail duplication
- People not getting the services they need resulting poor quality of life
- Institutional placements as opposed to community

Diversity

- Making sure service is reflecting the community such as First Nations
- Recognizing diversity

Family

- Family breakdown
- Not being supported by family

Systems challenges

- Clog up hospital beds waiting the right placement beds
- Not identified/lost in the system
- Flood will occur again and we won't have a first response approach for seniors
- Financial costs of running beds with wait lists
- Recognize senior homeless population as their own entity
- Unpredictable, inconsistent funding
- No one is watching, ignored, and isolated

Clients

- Risk physical violence and being robbed everyone knows cheque time
- Moving into unsafe housing/ couch surfing
- Fear of aging and not being respected/no alternatives
- Accidents/death due to inadequate support
- They will not open up and if they do family will shut it down
- Losing housing/rapid onset mental health issues
- Never leave unaware of what is available
- Increased risk of homelessness and mental illness
- Will not be heard and cared for/maybe Ronald MacDonald house for Seniors
- Ageism

- Isolation
- Stigma: cannot find support so isolated
- Dementia

10) What is the best service delivery model?

The responses to this question are as follows:

Outreach

- Door-to-door community based outreach services
- Outreach visited every 1-3 days
- Face-to-Face

Other Specific Models

- Persons with Developmental Disabilities
- Sharp Foundation (AIDS and HIV)
- Move and Mingle fall prevention program
- SCCOT (Seniors Collaborative Community Outreach Team)
- Neighborhood Houses - Vancouver and area

Characteristics of good service delivery

- Focus on wellness/sustainability/assets
- One-stop shopping
- Palliative and Home Care continuum
- Research and client centered
- Coordinated and strategic
- Inter and multi-disciplinary
- Relationship based
- Client-driven, wraparound services
- Early intervention and more resources
- 100% Participatory in development (involve client population?)
- Live independent as long as possible
- Better and more extensive housing

11) Who should lead it? Housing services/third party?

The responses to this question are as follows:

Collaborative

- Not a singular agency
- Multi-disciplinary
- Collaborative process

- Collective Impact
- Bring together and co-create
- Multi-disciplinary team and include funders and Calgary Homeless Foundation
- Communicated coordinated response
- Less bureaucracy more agencies

Particular agency

- The Way In
- The Alex or CUPS
- Local agency not government
- US Elder Justice Centre

Government

- AHS - Seniors Mental Health
- Government of Alberta
- City of Calgary like the Source

Other

- Professionals who know this population
- Third party
- Mixed with mental health and housing
- Full comprehensive assessment of all senior services

Appendix B – Agencies Interviewed

Organizational Name
1. CDN Mental Health Association
2. Hoad Consulting Silvera
3. Aspen
4. Fuqua Centre Late-Life Depression (removed)
5. Learning Age Georgia (removed)
6. Canadian Over 50 Housing Weekly (removed)
7. Canadian Coalition for Seniors Mental Health (removed
8. Alberta Health Services Addiction and Mental Health Calgary Zone
9. Geriatric Mental Health
10. Mustard Seed
11. DI
12. The Alex
13. Community Action Committee
14. City Calgary
15. Distress Centre
16. Mobile Response Team / ACCESS
17. PACT CPS
18. Jewish Family Services
19. Kerby Centre / Housing
20. Calgary Women's Emergency Shelter
21. Elizabeth Fry Society
22. John Howard
23. Calgary Dream Centre
24. Women In Need (removed)
25. CUPS
26. R-CAT/Service Health Centre
27. Silvera
28. Calgary Family Services
29. Trinity Foundation
30. YWCA Mary Dover and Sheriff King
31. Alpha House
32. Red Cross
33. Inn From The Cold
34. Calgary Housing Company
35. Salvation Army
36. Calgary Chinese Elderly Citizens Association
37. Calgary Catholic Immigration Society
38. Calgary Immigrant Women's Association
39. Immigrant Services Calgary
40. Alberta Caregivers Association
41. Meals on Wheels
42. Calgary Seniors Resource Society and Senior Connect
43. Elder Abuse Response Team
44. Homefront
45. SHARP Foundation
46. Bethany Care Society
47. Health and Housing AB Gov

11. Bibliography

Aboriginal Homelessness: Looking for a Place to Belong. Calgary: Aboriginal Friendship Center of Calgary, March 2010.

Adams, B. and Alberta Health Services. *Calgary Zone Clinical Department of Psychiatry 2013 Annual Report.* Calgary: University of Calgary, 2014. Retrieved from: http://www.ucalgary.ca/psychiatry/files/psychiatry/2013%20AHS%20Psychiatry%20Annual%20Report.pdf

Alberta Network of Senior-Related Organizations (ANSRO). *Supporting George and Betty: An Integrated Management Strategy for Seniors Supports, Housing and Care in Alberta*. Edmonton: ANSRO, December 2011. Retrieved from: http://www.ascha.com/PDF_files/rollout/2012/ANSRO%20White%20Paper%20December.pdf

Allen J., Ottmann G. and Roberts G. Multi-professional communication for older people in transitional care: a review of the literature. *International Journal of Older People Nursing* 8 (2013): 253–269.

Assembly of First Nations. *First Nations Regional Longitudinal Health Survey (RHS) 2002/03: Results for Adults, Youth and Children Living in First Nations Communities.* Ottawa: First Nations Centre, 2007. Retrieved from: http://fnigc.ca/sites/default/files/ENpdf/RHS_2002/rhs2002-03-technical_report.pdf

Baker, K. et al. *Person and Practice-Based Learning*. Toronto: Behavioural Supports Ontario, March 2012. Retrieved from: http://www.rehabresearch.ualberta.ca/behaviouralsupportsalberta/sites/default/files/Person%20and%20Practice-Based%20Learning%20141112_0.pdf

Bartels, S.J. Improving the system of care for older adults with mental illness in the United States. Findings and recommendations for the president's new freedom commission on mental health. *American Journal of Geriatric Psychiatry*, 11 (2003): 486-497. Retrieved from: http://www.cmhda.org/committees/documents/oasoc_ebp_(10-18-06)_bartels_(ajgp_2003).pdf

Behavioural Supports Ontario (BSO). *Complex Care Resolution for Older Adults with Responsive Behaviours.* n.p.: BSO, n.d. Retrieved from: http://www.akeresourcecentre.org/files/Behaviour/Complex_%20Care_Resolution.pdf

BC Psychogeriatric Association. *Meeting Seniors' Mental Health Care Needs in British Columbia: A Resource Document*. March 2012. Retrieved from: http://www2.gov.bc.ca/assets/gov/topic/AE132538BBF7FAA2EF5129B860EFAA4E/pdf/meetingseniorsmentalhealthneeds2012.pdf

BC Ministry of Health Services. *Guidelines for Elderly Mental Health Care Planning for Best Practices for Health Authorities.* Victoria, BC: Ministry of Health Services, 2002. Retrieved from: http://www.health.gov.bc.ca/library/publications/year/2002/MHA_elderly_mentalhealth_guidelines.pdf

BC Ministry of Health and Ministry Responsible for Seniors. *B.C.s Mental Health Reform — Best Practices*. Victoria, BC, 2000. Retrieved from: http://www.health.gov.bc.ca/library/publications/year/2000/MHABestPractices/bp_housing.pdf

Brémault-Phillips, Suzette. *Advancing Behavioural Supports Alberta: A Secondary Data Analysis of the November 21st, 2012 Challenging/Responsive Behaviours Symposium - Developing an Alberta Action Plan.* Edmonton: Institute of Continuing Care Education and Research (ICCER), October 2013. Retrieved from: http://www.bsa.ualberta.ca/sites/default/files/CB_Symposium_report_FINAL_02-12-2013.pdf

Brown, R.T. et al. Meeting the Housing and Care Needs of Older Homeless Adults: A Permanent Supportive Housing Program Targeting Homeless Seniors. *Seniors Housing and Care Journal.* 21, 3 (2013): 126-31. Retrieved from: file:///C:/Users/Lee/Downloads/SHCJ-NIC_2013_Meeting_the_Housing_and_Care_Needs_of_Older_Homeless.pdf

Bryant C, Jackson H & Ames D. The prevalence of anxiety in older adults: Methodological issues and a review of the literature. *Journal of Affective Disorders*. 109, 3 (2008): 233-250.

Butler-Jones, D. *The Chief Public Health Officer's Report on the State of Public Health in Canada 2010: Growing Older—Adding Life to Years*. Ottawa, Ontario: The Public Health Agency of Canada, 2010. Retrieved from: http://www.phac-aspc.gc.ca/cphorsphc-respcacsp/2010/fr-rc/pdf/cpho_report_2010_e.pdf

Burns, A., Lawlor, B., Craig, S. Rating scales in old age psychiatry. *The British Journal of Psychiatry*. 180 (2002): 161-167. Retrieved from: http://bjp.rcpsych.org/content/180/2/161.full

Calgary's Aging Population: An Overview of the Changing and Aging Population in Calgary. Calgary: City of Calgary, November 2011. Retrieved from: http://www.calgary.ca/CSPS/CNS/Documents/Social-research-policy-and-resources/calgary-aging-population.pdf?noredirect=1

Canada Mortgage and Housing Corporation (CMHC). *Supportive Housing for Homeless and Hard-to-HouseSeniors: An In-depth Case Study*. Socio-economic Series 07-017. Ottawa: CMHC, September 2007. Retrieved from: ftp://ftp.cmhc-schl.gc.ca/chic-ccdh/Research_Reports-Rapports_de_recherche/eng_unilingual/Housing_Homeless_HH_Seniors(w).pdf

CMHC. *Rental Market Outlook- Alberta Highlights: Spring 2013*. Ottawa: CMHC, 2013. Retrieved from: http://www.crra.ca/wp-content/uploads/2013/06/2013-Spring-Rental-Market-Highlights-for-Alberta.pdf

CMHC. *Rental Market Outlook- Alberta Highlights: Fall 2013*. Ottawa: CMHC, 2013. Retrieved from: http://www.cmhc-schl.gc.ca/odpub/esub/64371/64371_2013_A01.pdf?fr=1398552523893

Canada's Most Vulnerable: Improving health care for First Nations, Inuit, and Métis seniors. Ottawa: Health Council of Canada, November 2013. Retrieved from: file:///C:/Users/Lee/Downloads/Senior_AB_Report_2013_EN_final.pdf

Canadian Institute for Health Information (CIHI). *Depression among Seniors in Residential Care.* Ottawa, ON: CIHI, 2010a. Retrieved from: http://www.cmha.ca/download.php?docid=98

Canadian Coalition for Seniors' Mental Health (CCSMH). *National Guidelines for Seniors' Mental Health: The Assessment of Suicide Risk & Prevention of Suicide.* Toronto: CCSMH, 2006.

CCSMH. *Delirium in Older Adults: A Guide for Seniors and their Families.* Toronto: CCSMH, 2006.

CCSMH. *National Guidelines for Seniors' Mental Health: The Assessment & Treatment of Depression.* Toronto: CCSMH, 2006.

CCSMH. *National Guidelines for Seniors' Mental Health: The Assessment and Treatment of Mental Health Issues in Long Term Care Homes (Focus on Mood and Behaviour Symptoms).* Toronto: CCSMH, 2006.

Caresce Inc. and MK Strategy Group, Inc. *Seniors and Special Needs Housing in Calgary*. Calgary: The Seniors and Special Needs Housing Sector Advisory Committee, July 2010. Retrieved from: http://calgaryhomeless.com/assets/CAC/Seniors-and-Special-Needs-Housing-in-Calgary-Final.pdf

Cassidy K-L, Rector N. The Silent Geriatric Giant: Anxiety Disorders in Late Life. *Geriatrics and Aging*. 11, 3 (2008): 150-6. Retrieved from: http://www.medscape.com/viewarticle/579825

Centre for Addiction and Mental Health (CAMH) Healthy Aging Project. *Responding to Older Adults with Substance Use, Mental Health and Gambling Challenges: A Guide for Workers and Volunteers*. Toronto: CAMH, 2006). Retrieved from: http://www.jogoremoto.com/docs/extra/WxyK3E.pdf

City of Calgary. *2011 Civic Census Results.* Calgary: City Clerk's Election and Information Services, 2011. Retrieved from: http://www.calgary.ca/CA/city-clerks/Documents/Election-and-information-services/Civic-Census/2011_census_result_book.pdf

Creating Connections: Alberta's Addiction and Mental Health Strategy. Edmonton: AHS and Government of Alberta, 2011. Retrieved from: http://www.health.alberta.ca/documents/Creating-Connections-2011-Strategy.pdf

Davis, L., et al. *Signposts II: Seniors Theme Report*. Calgary: City of Calgary and United Way, September 2012. Retrieved from: http://www.calgary.ca/CSPS/CNS/Documents/signposts/Sign%20Posts%20II%20-%20SENIORS%20Theme%20Report.pdf

Draper B., Brodaty, H., & Low, LF. A tiered model of psychogeriatric service delivery: an evidence-based approach. *International Journal of Geriatric Psychiatry*, 21 (2006): 645-653.

Draper B, Low L. *What is the effectiveness of old-age mental health services?* Copenhagen: WHO Regional Office for Europe, 2004. Retrieved from: http://www.euro.who.int/document/E83685.pdf

Egervari, M. and Shin, W. *Supportive Housing Services for Seniors with Mental Illness and the Stepping Stone Project.* Toronto: LOFT, January 25, 2011. PowerPoint presentation.

Frankel, M., Freed, G and Isenberg, L. *Tips and Techniques for Supporting Residents with Mental Illness: A Guide for Staff in Housing for Older Adults.* Jewish Community Housing for the Elderly and Jewish Family & Children's Service, Boston, 2012. Retrieved from: http://www.jfcsboston.org/LinkClick.aspx?fileticket=5mk9jq%2BxWVU%3D&tabid=395&mid=1079

Health Council of Canada. *Canada's Most Vulnerable: Improving health care for First Nations, Inuit, and Métis seniors*. Toronto: HCC, 2013. Retrieved from: http://publications.gc.ca/collections/collection_2013/ccs-hcc/H174-40-2013-eng.pdf

Hébert, R. et al. Frail Elderly Patients: New Model for Integrated Service Delivery. *Canadian Family Physician.* 49 (2003): 992-97. Retrieved from: file:///C:/Users/Lee/Documents/OASPoC/Resources/PRISMA_QC.pdf

Hébert, R. et al. PRISMA: a new model of integrated service delivery for the frail older people in Canada. *International Journal of Integrated Care*. 3 (2003): 1-8. Retrieved from: file:///C:/Users/Lee/Downloads/73-230-1-PB.pdf

Hébert, R. Tourigny, A., Gagnon, M. *Integrated service delivery to ensure persons' functional autonomy.* Saint-Hyacinthe, Quebec: Edisem, 2005. Retrieved from: http://www.prismaquebec.ca/documents/document/Prisma_English.pdf

Hightower, H.C., Hightower, J. and Smith, M.J. *Out of Sight, Out of Mind: The Plight of Seniors and Homelessness.* New Westminster, BC: Seniors Housing Information Program, 2003. Retrieved from: http://www.urbancentre.utoronto.ca/pdfs/elibrary/plight.pdf

Jeste, D., et al. Consensus statement on the upcoming crisis in geriatric mental health research agenda for the next two decades. *Archives of General Psychiatry*, 56 (1999): 849.

Jorm, A., MacKinnon, A., Henderson, A. S., et al. Psychogeriatric Assessment Scales. A multidimensional alternative to categorical diagnosis of dementia and depression in the elderly. *Psychological Medicine*, 25 (1995): 447 -460.

Kodner, D. L. and Kyriacou, C.K. Fully integrated care for frail elderly: two American models. *International Journal of Integrated Care*. 8 (2000). Retrieved from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1533997/

Komarnicki, J. All Sunnyhill residents moved to new homes. *Calgary Herald*, 26 May 2014.

Retrieved from: http://www2.canada.com/calgaryherald/news/city/story.html?id=ec5c29ee-2ace-4c64-823a-daf380e872d1

LeClair, K., Hedges, J. and Abbott-MacNeil, D. *PCTBSL: Person-Centred Team-Based Service-Learning.* Toronto: Behavioural Supports Ontario, March 2012. Retrieved from: http://www.bsa.ualberta.ca/sites/default/files/PCTBSL%20-%20Final%20March%2028_rev3July2012.pdf

Lee, D. Bridgeland Manor. *Bridges.* Calgary: Bridgeland-Riverside Community Association, October 2013. Retrieved from: http://brcacalgary.org/wp-content/uploads/sites/2/2013/10/Bridgeland-Oct-2013.pdf

Leichsenring, K. Developing integrated health and social care services for older persons in Europe. *International Journal of Integrated Care*. (2004). Retrieved from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1393267/

Leutz, WN. Five laws for integrating medical and social services: lesson from the United States and the United Kingdom. *The Milbank Quarterly*. 77, 1 (1999):77–110.

MacAdam, Margaret. *Frameworks of Integrated Care for the Elderly: A Systematic Review*. Ottawa: Canadian Policy Research Network, 2008. Retrieved from: http://www.cprn.org/documents/49813_EN.pdf

MacCourt, P. *Promoting Seniors' Well-Being: A Seniors' Mental Health Policy Lens Toolkit.* Victoria, BC: British Columbia Psychogeriatric Association, 2008. Retrieved from: http://www.mentalhealthcommission.ca/English/system/files/private/Seniors_Seniors_Mental_Health_Policy_Lens_Toolkit_ENG_0.pdf

MacCourt P., Wilson K., and Tourigny-Rivard, M-F. *Guidelines for Comprehensive Mental Health Services for Older Adults in Canada.* Calgary, AB: Mental Health Commission of Canada, 2011. Retrieved from: http://www.cmhawpg.mb.ca/documents/seniors-guidelines.pdf

Mattessich, P.W., Murray-Close, M., Monsey, B.R. *A review of research literature on factors influencing collaboration.* St Paul, MN: Wilder Publishing Center, 2004.

McDonald, L. et al. *Final Report: In From the Streets: The Health and Well Being of Formerly Homeless Older Adults.* Np: National Research Program of the National Homelessness Initiative, September 2006. Retrieved from: http://homeless.samhsa.gov/ResourceFiles/NRP_027_EN_InFromtheStreets__The_Health_and_Well_Being.pdf

Mental Health Drug and Alcohol Office. *NSW service plan for specialist mental health services for older people (SMHSOP) 2005-2015.* North Sydney, NSW: NSW Department of Health, 2006. Retrieved from: http://www0.health.nsw.gov.au/policies/gl/2006/pdf/GL2006_013.pdf

Mental Health and Addictions Issues for Older Adults: Opening the Doors to a Strategic Framework. Toronto: Canadian Mental Health Association Ontario. March 2010. Retrieved from: http://ontario.cmha.ca/download.php?docid=433

Ministry of Health and Long Term Care (Ontario) Advisory Committee. *Continuum of Health and Long-Term Care Services for Seniors with Mental Health Needs and their Carers/Caregivers*. 2003. Retrieved from: http://www.hnhblhin.on.ca/uploadedFiles/Public_Community/Aging_at_Home/Specialized_Geriatric_Services/Continuum%20for%20Seniors(1).pdf

National Initiative for the Care of the Elderly (NICE) and Canadian Coalition for Seniors' Mental Health. *Tool on Depression: Assessment & Treatment for Older Adults*. Retrieved from: http://www.ccsmh.ca/pdf/CCSMH_depressionBrochure.pdfNational Guidelines for Seniors' Mental Health. *The Canadian Journal of Geriatrics* 9, Supplement 2 (2006).

New South Wales Severe and Persistent Challenging Behaviours Project. *The Management and Accommodation of Older People with Severe and Persistent Challenging Behaviours in Residential Care*. Sydney: The Centre for Mental Health, NSW Department of Health, April 2004. Retrieved from: https://www.ranzcp.org/Files/Resources/FPOA_Report_July_2006-pdf.aspx

Ontario Behavioural Support Systems: A Framework for Care. Toronto: Alzheimer Society Ontario, Alzheimer Knowledge Network, Ontario Local Health Integration Network, 2010. Retrieved from: http://www.akeresourcecentre.org/files/Readiness-for-Change-0/Framework%20of%20Care%20BSS%2011X17.pdf

Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada. Ottawa: The Standing Senate Committee on Social Affairs, Science and Technology, 2006. http://www.parl.gc.ca/content/sen/committee/391/soci/rep/rep02may06-e.htm

Ploeg, J., et al. A case study of a Canadian homelessness intervention programme for elderly people. *Health and Social Care in the Community* 16, 6 (2008): 593-605. Research summary retrieved from: http://www.homelesshub.ca/ResourceFiles/HomelessnessIntervention_Summary.pdf

Quick Facts: Mental Illness and Addiction in Canada. Guelph, ON: Mood Disorder Society of Canada, 2009. Retrieved from: http://www.mooddisorderscanada.ca/documents/Media%20Room/Quick%20Facts%203rd%20Edition%20Eng%20Nov%2012%2009.pdf

Reach Up, Reach Out - Best Practices in Mental Health Promotion for Culturally-Diverse Seniors. Ottawa: Victorian Order of Nurses, n.d. Retrieved from: http://www.von.ca/en/special_projects/docs/RR_manual.pdf

Sadavoy J, Meier, R and Ong, AYM. Barriers to access to mental health services for ethnic seniors: The Toronto study. *Canadian Journal of Psychiatry* 49, 3(2004): 192 – 199. Retrieved from: https://ww1.cpa-apc.org/Publications/Archives/CJP/2004/march/sadavoy.pdf

Saskatoon Housing Initiatives Partnership. *Best Practices in Seniors' Housing*. Retrieved from: http://shipweb.ca/best-practices-in-seniors-housing/

Schizophrenia Society of Canada. Information for Service Providers: Schizophrenia and Substance Use. Winnipeg: SSC, n.d. Retrieved from: http://www.schizophrenia.ca/docs/SSC_for_Service_Providers.pdf

Serge, L. and Gnaedinger, N. *Housing options for elderly or chronically ill shelter users*. Ottawa: CMHC, 2004. Retrieved from: http://www.cmhc-schl.gc.ca/odpub/pdf/63296.pdf?fr=1397236743043

Shiner, Donald, et al. *Seniors' housing: challenges, issues, and possible solutions for Atlantic Canada: Final Report of the Atlantic Seniors Housing Research Alliance*. Halifax: Atlantic Seniors Housing Research Alliance, 2010. Retrieved from: http://www.fredericton.ca/en/communityculture/resources/Englishwcovers.pdf

Thornton, L. Person-centred dementia care: An essential component of ethical nursing care. *Canadian Nursing Home*. 22, 3 (2011): 10-14.

Turcotte, M. and Schellenberg, G. *A Portrait of Seniors in Canada, 2006*. Ottawa: Minister of Industry, 2007. Retrieved from: http://www.statcan.gc.ca/pub/89-519-x/89-519-x2006001-eng.pdf

United Way of Calgary and Area. *Current Research in the Seniors Sector: A Summary*. Calgary: United Way, May 2008. Retrieved from: http://www.link-ages.ca/pdfs/researchdocs/unitedway_researchsummary.pdf

Walko, D. and Egervari, M. *An Empirical Study of Supportive Housing for Older Persons with Mental Illness.* np, nd. Retrieved from: www.ccsmh.ca/ppt/A4b.pps

Wells, Greg, et al. *Supports and Barriers to Independent Living and Mental Wellness in Seniors and Persons with Disabilities*. np: Alberta Health Services and Alberta Mental Health Research Partnership Program, nd. Retrieved from: http://www.mentalhealthresearch.ca/KeyInitiatives/ResearchGrants/Seniors_PwD/Documents/RDC_backgrounder_FINAL.pdf

Woolrich, R. and Gibson, N. Senior Homelessness in metro Vancouver: Strategies and Best Practices. *Seniors' Housing Update* 22, 3 (2013).