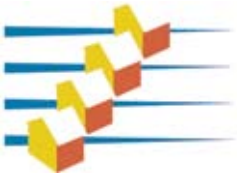
REPORT

on the Atlantic Seniors' Housing and Support Services Survey



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Background

Where and how we live is a reflection of where we are in our lifecourse (Gonyea, 2005; Hudson, 2005; Iwarsson, 2005). It has been two decades since Litwak and Longino (1987) drew on a family cycle/lifecourse framework in their approach to moving their residence after age 60. They describe three distinct types of moves during later life:

- a primary retirement move to be closer to amenities,
- a move to adapt to moderate disability levels, and
- a move in the face of major, chronic disability that usually results in institutionalization.

Since then, other researchers (Gonyea, 2005; Iwarsson, 2005; Kitchener et al., 2006; Ostrovsky, 2004; Oswald et al., 2007) have documented that such moves are affected differently by retirement lifestyle, family ties, and health. Some life events impact the individual's housing situation immediately, for example, marriage or co-habiting. Other life events have a lagged effect (Kendig, 1990), such as a job loss leading to a move to less expensive housing after the household has run out of savings. Some effects may last over time while others may disappear or recur. Moreover, a long-term perspective on the housing situation acknowledges the importance of the accumulation of experiences up to a certain moment to explain the situation at that time. As Dykstra and Van Wissen (1999) state: "people's biographical pasts affect their present circumstances, and present circumstances shape future life directions." (p. 8) Mayer (1986) uses the term, "cumulative contingencies" to stress the cumulative way in which the occurrence and timing of events in different domains of life result in restrictions and opportunities at a particular age.

As we age, the choice of living arrangement is affected by the interplay of a number of household characteristics and not just age. For example, one would expect frailty—the ability of older adults to perform daily living activities—to be an important factor in the selection of living arrangement. Despite the certainty of aging, many want to remain in their own homes. The reasons for wanting to stay where we are as we age have variously been identified as:

- Familiarity, comfort, and meaning associated with home (Herzog and House, 1991; Rowles, 1987; Rubinstein, 1989; Oswald et al., 2007).
- Feelings of independence and control (Wagnild, 2001; Iwarsson, 2005).
- Economics (Cutler and Gregg, 1991; Mutschler, 1992; Kitchener et al., 2006).
- Benefits associated with remaining in a familiar neighbourhood and community (Antonucci and Akiyama, 1991; Schieman, 2005).

Together, these factors result in an aging population that becomes less accepting of the possibility of having to move as they age. At the same time, the actual probability of that very event happening increases with every passing year. The one traumatic situation that runs counter to this need to move to adapt to moderate disability levels or in the face of major, chronic disability that may result in institutionalization, is a move motivated by the death of a spouse. Interestingly, the chances of moving have proven to be reduced, rather than raised, for this situation (Lin, 2005).

A number of studies have specifically asked seniors about their future plans to move. In the USA, the American Association of Retired Persons (AARP) has consistently reported that 9 out of 10 seniors want to stay where they are (*Fixing to Stay*, AARP, 2000). Our Atlantic Canadian respondents resoundingly gave the same message, with 88% saying they have no plans to move from their current dwelling. As with many actions over an individual's lifecourse, there is an obvious discrepancy between what we think we will do and what we actually do. For example, research on moving by seniors indicates that those who move will move for various reasons including the desire to live in a smaller home, wanting to be closer to family, relocating to a better neighbourhood, a decline in health, and access to more recreation and leisure activities (Che-Alford and Stevenson, 1998).

Schafer (1999) categorized the housing choices of the elderly into five types: assisted communities, unassisted 60-plus communities, shared housing, supported housing and conventional housing. He reported that education, income, net worth and sex have little to do with the selection of one of the living arrangements. Schafer's study concluded that:

- Assisted communities are favoured by older households (especially those with the oldest person over 85) and when there are no children living within ten miles.
- Unassisted 60 plus communities are generally favoured by healthy persons.
- Shared housing is favoured by households who have difficulties with

activities of daily living or instrumental activities of daily living and by households without resident children. Willingness of adult children to establish a shared housing arrangement with a parent substantially increases the likelihood of selecting this alternative. Many of these living arrangements involve unconventional tenure arrangements that are neither renting nor owning. Households that lack elderly drivers also gravitate towards this alternative.

- Supported housing is favoured by households having difficulties with activities of daily living or with instrumental activities of daily living. Households with greater cognition tend to favour supported housing. Divorced/separated and widowed households also favour supported housing while the likelihood of selecting this alternative decreases as the number of non-resident children increases. Households without an elderly driver also turn to this alternative as a solution to their lack of mobility.
- Conventional housing is preferred by households that are younger, married with spouse present and children living nearby or resident children. It also tends to be owner-occupied and is more prevalent in non-metropolitan areas.

As we age, it appears we become more attached to our homes and our community. Ask almost anyone a direct question about satisfaction with their current housing and you typically receive a simple straight-forward yes or no answer, with that answer usually being positive. In Atlantic Canada, 91.7% of respondents to the *Seniors Housing and Support Services Survey* (2007) indicated that such positive satisfaction was the case with their housing situation. Another simple question one could ask is whether a person wants to move or stay in their current housing situation. Betty Friedan (1993) answered this question by stating that "whether to move to a new place or simply to stay where we are, that is the deceptive, impossible metaphor of choice we put to ourselves facing age." (p. 347)

As we grow older and seek ways to continue to live in the home we have established, we turn to modifying that dwelling to make it more suitable. There are a number of design features which we currently understand work together to create both a healthy and thriving environment for seniors. These design features have a relationship with the activities of daily living (ADLs) and instrumental activities of daily living (IADLs). ADLs are basic tasks that people do everyday to be able to live, such as eating, walking, bathing, and toileting, while IADLs refer to the more tangible tasks people carry out on a regular basis, including banking, groceries, and housework.

Regnier and Pynoos first compiled six of these design features in their 1987 book, *Housing the Aged*. The original list of design features included resident satisfaction, social interaction, management, sensory aspects, physiological constraints, and way-finding. In his more recent work, *Design for Assisted Living: Guidelines for housing the physically and mentally frail* (2002), Regnier modified his original list of design directives to include additional features identified as important to seniors' thriving. The expanded list of 12 design principles and their relationship to the activities of daily living is defined below:

TABLE 1 DESIGN GUIDELINES FOR HOUSING ELDERLY AND FRAIL

Design concept	This design principle is important because:
1. Privacy	It provides the older person with a sense of self and of separateness from others. Auditory and visual privacy are important components of physical separation. Privacy is more difficult to ensure in group living arrangements.
2. Social interaction	One of the basic reasons for creating age-segregated group living arrangements is to stimulate informal social exchange, recreational activities, discussion groups, and friendship development. Social interaction counters depression by allowing older people to share problems, life experiences, and daily events.
3. Control, choice/ autonomy	Older (Pynoos and Cohen, 1987) persons are often more alienated, less satisfied, and more task-dependent in settings that are highly restricted and regimented. Having a sense of mastery and control has been found to have pronounced positive effects on life satisfaction. Independence is often defined by our ability to make choices, control events, and to remain autonomous.

4. Orientation/ way-finding	Feeling lost or being disoriented within a building is a frightening and disconcerting feeling that can lessen confidence and self-esteem. Older people who have experienced some memory loss are more easily disoriented within a featureless, symmetrical, complex environment. Signs can overcome some problems, but they never provide a person with the confidence of knowing exactly where they are within the larger environment.
5. Safety/ security	Older people may experience physiological and sensory problems such as visual impairments, balance control difficulties, loss of lower body strength, and arthritis, which make them more susceptible to falls and burns. Reductions in bone calcium levels with aging can also increase their susceptibility to broken bones and hips. Older adults experience a high rate of injury from home accidents.
6. Accessibility and functioning	Older people often experience difficulties manipulating the environment. Windows, doors, HVAC controls, and bathroom fixtures can be hard to twist, turn, and lift. Furthermore, older people confined to a wheelchair or dependent on a walker must have environments that are adaptable enough to accommodate these devices. Reach capacity and strength limitations are therefore important considerations in the layout of bathrooms and kitchens, and in the specification of finishes.
7. Stimulation/ Challenge	A stimulating environment keeps the older person alert and engaged. Stimulation can result from colour, spatial variety, visual pattern, and contrast. Stimulation can also involve animating the setting with intergenerational activities, pet therapy, or a music program. Environments overly concerned with maintenance and cleanability are often uniform in colour and pattern, noisy and disconcerting to the ear, and glaring and reflective in appearance. Each resident is different and should be allowed to experience an optimum level of complexity and challenge.

8. Sensory Aspects	Older people tend to suffer age-related sensory losses. Smell, touch, sight, hearing, and taste decrease in intensity as a person ages. Sensory stimulation can involve aromas from the kitchen or garden, colours and patterns from furnishings, laughter from conversations, and the texture of certain fabrics. A range of sensory inputs can be used to make a setting more stimulating and interesting.
9. Familiarity	Moving into a new housing environment is a very disorienting experience for some older people. Creating continuity and connection with the past is reassuring and facilitates the transition. Residents take cues from the environment. When it is designed to accommodate traditional events and fits into the regional housing vernacular, it appears more predictable and understandable. Institutional environments often use imagery that does not come from housing examples and therefore appears cold and alienating.
10. Aesthetics and Appearance	The overall appearance of the environment sends a strong symbolic message to visitors, friends, and relatives about the older person. Housing that appears institutional provides negative cues to others about the competence, well-being, and independence of residents. Staff and care-giving personnel are also highly affected by the appearance of the physical and policy environment. Personnel working in a building that resembles a nursing home will reduce cognitive dissonance and act in ways that are consistent with an institutional context.

11. Personalization	It allows older residents to express self-identity and individuality. In nursing homes, individual expression is often very limited. Patients do not have much personal space in compact two-bedroom accommodations furnished with hospital beds and over-the-bed trays. Personal items used for display and decoration are often very important and salient to the older person. Collectible items may trigger memories of travel to other countries or emotional bonds with family and friends. These items can animate a room by recalling past associations.
12. Adaptability	Older people age differently. Some have mental impairments, while others suffer visual losses or other physical impairments. Chronic arthritis keeps some persons from performing ADLs, while for others, arthritis is an occasional annoyance rather than a disabling disease. The environment has the capacity to compensate for many deficits and to adapt to changing resident needs. Bathrooms and kitchens are the major rooms where work activities take place and where safety is a major consideration. Environments should be designed to be adaptable to a range of users, including those who need wheelchairs and walkers.

It is a combination of many factors that will ultimately determine the path of one's lifecourse and the role that housing plays over the time of that lifecourse. The ASHRA Seniors' Housing and Support Services Survey was designed to explore these factors.

Introduction to the ASHRA Seniors' Housing and Support Services Survey

This report presents an overview of the results of a survey of 1702 Atlantic Canadian seniors aged 65 years and older completed in early 2007. In this survey, we asked our seniors detailed questions about where and how they live. We wanted to understand how their current situation meets their expectations and where they thought they might be living in the future. The demographics of this sample of Atlantic Canadian seniors are described below in Table 1. The sample is considered to be representative of Atlantic Canadian seniors, so the results can be generalized to this same group.

TABLE 2 Sample description

		Atlantic	NS	NB	NL	PE
Gender	Male	41.8	36.3	40.8	49.3	40.6
	Female	58.2	63.7	59.2	50.7	59.4
		n=1678*	n=369	n=520	n=402	n=387
Age	Under 65	1.8	1.1	1.6	1.5	2.3
	65-74	60.4	57.0	62.0	62.2	59.7
	75-84	30.4	32.6	30.3	29.5	29.9
	85-94	6.8	8.1	6.1	6.5	7.3
	95+	0.7	-	-	-	-
		n=1646	n=357	n=507	n=397	n=385
Marital status	Married or common-law	65.0	63.8	63.3	67.3	66.2
	Separated or divorced	6.2	7.0	8.5	3.7	5.1
	Widowed	25.6	26.5	25.2	27.2	23.6
	Never married	3.2	2.7	3.1	1.7	5.1
		n=1681	n=370	n=520	n=401	n=390

*Tables throughout this report only include valid responses.

All statistics reported in the text of this report deal with the whole Atlantic Canadian sample; however, where significant differences were present, provincial data are included in table format.

This report is organized around eight themes that correspond to the survey questions as follows:

- Where seniors live and their residences
- Current dwellings of seniors and how well they meet the needs of
- their residents
- Future housing plans of our seniors
- How transportation issues impact our seniors
- Activities of everyday living and health
- Current support service use and needs of Atlantic seniors
- Current social supports and needs of our seniors
- Current income, financial status and needs of our seniors

Project Background

The ASHRA project was designed to answer two primary questions regarding the future of housing options for the aging demographic of Atlantic Canadian seniors:

1. What will the housing needs of aging Atlantic Canadians be over the next 20 years? and
2. What housing options, support services, and policies should be developed to meet these needs?

To answer these questions, a challenging research initiative was undertaken: *Projecting the Housing Needs of Aging Atlantic Canadians.* This 5-year, federally funded project arose from the collective efforts of a research alliance initiated in 2004, encompassing all four Atlantic Provinces and representing universities, seniors' and other community-based organizations, housing developers, service providers, and government departments. From this diverse group of academic researchers, community partners, and stakeholders, the Atlantic Seniors Housing Research Alliance (ASHRA) was formed. ASHRA represents all of the organizations involved in this Community University Research Alliance (CURA) grant. The CURA grant was awarded by the Social Sciences and Humanities Research Council of Canada (SSHRC).

The goal of the CURA is to answer the two primary questions presented above through a series of research activities, while concurrently building capacity among academic researchers and community organizations to conduct meaningful and useful collaborative research. The ASHRA project is driven by

four major research questions. These questions are addressed in four project phases through a series of related research activities:

1. Can we predict the likely housing needs of the 50+ population in 2026 based on current trends in population, health and wealth? (Phase 1)
2. What are the current needs, challenges and issues around housing faced by seniors today? (Phase 2)
3. What housing solutions are emerging around the world and how could these be applied here? (Phase 3)
4. How do policies impact supply and demand for seniors housing and how might these better match future needs? (Phases 3–4)

Phase 1
began in early 2005 and was completed in December 2005. It addressed question 1 (above) through the development of an on-line geo-demographic community profile model. The model is based on the 2001 Census and other Statistics Canada data and allows anyone with access to the Internet to profile the senior population in their community in Atlantic Canada (using the first three identifiers of their postal code) based on age, sex, health, and wealth, up to the year 2026. As health and wealth are two of the four principal predictors of housing choice, the model has been successfully used by government and community groups to understand the changing housing needs of seniors in their regions as they develop projects and plan for the future.

Phase 2
began in January 2006 and was designed to answer question 2 (above). The goal of Phase 2 was to gather information from as many seniors as possible from all four Atlantic provinces about their experiences, needs, and plans for the future as related to housing and support services. To give these seniors a voice, ASHRA conducted two major field research studies:

- Over 1700 seniors across the region completed a *68-page, detailed survey* about their housing and support service needs. The survey process actively involved our community partners and resulted in a detailed picture of the housing and support service situation and needs of Atlantic Canada's seniors. Appendix A contains detailed information on the survey methodology and sample characteristics.
- Another approximately 120 seniors participated in *focus group discussions* about their housing. These focus groups were moderated by trained and experienced community partners and engaged seniors with unique

housing needs (e.g. immigrant or Aboriginal seniors, seniors with disabilities or literacy issues).

Phase 3
began this Summer in July 2007. It addresses questions 3 and 4 (above). During this phase of the project, ASHRA will investigate the development of a searchable on-line inventory of seniors housing options currently available in Atlantic Canada. It will also explore the current policies and programs at all levels of government that impact housing and support services for seniors, as well as identify gaps based on the needs and plans of seniors identified in Phase 2. Finally, Phase 3 will explore emerging innovative approaches to seniors housing around the world through a series of case studies.

Phase 4
will focus on the dissemination of the knowledge developed in Phases 1-3, and the development of recommendations to government, community, and the private sectors as they plan for future improvements to seniors housing and support services. Phase 4 will culminate in an Atlantic Canada Seniors Housing Conference in May 2009 that will bring together all ASHRA community partners and stakeholders to review the findings of the project and plan for future action.

• • •

The Atlantic Seniors Housing Research Alliance began with 37 members from all four Atlantic Provinces, with representatives coming from various walks of life, including universities, seniors' and other community-based organizations, housing developers, service providers, and government departments. Over the last 2 years, members of the Alliance have continued to reach out and develop relationships with other organizations and individuals interested in seniors housing issues. To date, we have over 75 members participating in the Alliance.

Theme 1

A profile of where seniors live and their residences

Key Points

- As previously noted, our seniors have typically lived for a long time in their current dwelling, whether it is in an urban or a rural setting.
- Most people surveyed indicated that their dwelling has two or three bedrooms, with three-quarters of these being single-family dwellings, and 12.1% living in apartments.
- Almost 1 in 5 of the single detached homes seniors live in was built before 1946 (WWII).
- Atlantic Canada's seniors are not as likely to live in an apartment as other Canadian seniors and are more likely to live in mobile homes.

How rural are seniors?

Atlantic Canada has a greater portion of its citizens living in rural areas when compared with the rest of Canada. In fact, Statistics Canada (2001) estimated that 55% of the population of PEI was rural compared to 20% of all Canada. (Statistics Canada, Censuses of Population, 1851–2001)[1]. This is the highest proportion of rural living in our country. Seniors, of course, make up an important and growing part of this population.

Our respondents came from the following types of communities:

TABLE 3 Type of community

	Atlantic	NS	NB	NL	PE
Town	27.8	26.5	24.0	45.8	15.7
City	30.0	19.5	32.0	29.6	37.8
Village	12.5	17.4	15.8	4.0	12.1
Rural area <10 km from town/city	10.2	16.6	10.7	2.7	11.1
Rural area >10 km from town/city	19.5	20.1	17.4	17.9	23.4
	n=1677	n=374	n=512	n=402	n=389

1 The rural population for 1981–2001 refers to persons living outside centres with a population of 1,000 *and* outside areas with 400 persons per square kilometre.

If we consider villages as having fewer than 1,000 residents, we have 57.8% urban and 42.2% rural respondents.

If we consider all locations other than cities as rural, we have the following rural/urban split:

TABLE 4 Rural versus urban distribution of seniors homes

	Atlantic	NS	NB	NL	PE
Rural	70.0	80.3	68.0	70.4	62.2
Urban	30.0	19.7	32.0	29.6	37.8
	n=1678	n=375	n=512	n=402	n=389

How long have they lived in their community?

Our seniors have lived where they are now for a long time with 53.4% living in the same community for over 35 years, while only 8.6% have lived for 5 years or less in their current community.

Many reasons were identified for why the individual decided to move to their current community, with being near family and friends, followed by employment as the dominant ones as indicated in the following table.

TABLE 5 Reason for moving to current community

	Atlantic	NS	NB	NL	PE
Employment	32.4	27.8	34.5	39.0	27.5
Spouse/partner lived there	20.1	20.4	21.2	20.7	17.9
Family/friends lived there	34.5	34.2	35.1	35.1	33.5
Climate and natural environment	11.2	10.7	13.8	8.4	10.9
Better/more health care services	7.5	5.8	7.4	11.0	6.0
Better/more recreation facilities/services	4.3	4.4	3.5	5.8	3.9
Better/more suitable housing	9.7	9.6	10.7	8.4	9.6
Lower cost of living	13.9	11.8	16.2	13.4	13.5
Downsizing from a larger dwelling to a smaller one	11.2	14.0	9.7	7.6	14.0
Easier to get around there	10.3	9.9	11.7	9.7	9.6
Less physical effort to maintain home/garden	8.0	9.1	9.0	5.8	7.8
Better access to transportation	3.5	4.7	2.5	5.8	1.3
Return to roots	13.3	15.4	14.0	10.2	13.5
Decline in personal health	3.7	3.6	4.3	2.4	4.2
Decline in health of spouse/partner	2.7	1.9	3.3	2.1	3.1
Death of spouse/partner	3.6	3.6	3.3	3.1	4.4
Other	16.1	14.9	14.2	16.5	19.5
	n=1643	n=363	n=513	n=382	n=385

What type of dwellings do our seniors live in?

Our seniors typically own the dwelling they are living in, with 78% owning, 19.5% renting or living rent free, and 2.8% having "other" living arrangements. The majority (94.6%) live year-round in that dwelling. In terms of the type of dwelling, we found that the majority of those living in both rural and urban areas are in single-family dwellings, with 82.6% of rural seniors in single-family dwellings compared to only 59.9% of urban seniors. Overall, 75.8% of Atlantic Canadian seniors live in a single-family house. Apartments are the next most common type of dwelling, with 23.6% of urban seniors and 7.1% of rural seniors indicating this type of dwelling as their residence.

TABLE 6 Current dwelling type

(n=1677)	Rural/Urban		
	Rural	Urban	Total
Single-family house	82.6	59.9	75.8
Semi-detached, duplex, row house, townhouse	2.5	7.5	4.0
Suite/room within a house/ in-law suite	1.6	3.0	2.0
Apartment building/multiplex complex	7.1	23.6	12.1
Mobile home	4.2	1.0	3.2
Other	2.0	5.0	2.9

When we compare basic housing choices of Atlantic Canadians with other Canadians aged 65 and older we find that Atlantic Canada's seniors are more likely to live in houses rather than apartments, and that we have a much greater proportion of seniors who live in mobile homes. This is illustrated in the following table:

TABLE 7 Comparison of Canada to Atlantic Canada – housing choices

Those 65 and older in private households	2001 Census	2007 ASHRA survey
Houses	69	81.8
Apartments	29	12.1
Mobile homes	1	3.2

The fact that Atlantic Canada's seniors are more likely to live in houses reflects a more rural population where single-family detached homes are more the norm than in urban areas.

The average (mean) length of time that our seniors have lived in their current dwelling is just over 25 years, with 15.9% of the sample indicating that they have lived in their current dwelling for more than 45 years. Many of the dwellings were built before World War II as indicated in the following table:

TABLE 8 Year dwelling was built

	Atlantic	NS	NB	NL	PE
Before 1946	18.9	24.7	19.4	10.9	21.0
1946-1955	10.2	7.5	11.2	13.3	8.3
1956-1965	14.7	14.4	15.8	20.0	8.3
1966-1975	19.4	17.2	20.0	22.1	17.7
1976-1985	15.2	15.2	13.4	18.1	14.5
1986-1995	12.5	11.2	11.4	9.6	18.3
1996-2005	8.7	9.5	8.8	5.6	11.0
2006	0.3	0.3	0.0	0.3	0.8
	n=1595	n=348	n=500	n=375	n=372

The majority of our respondents share their dwelling with one other person (63.4%), while 26% live alone. These findings are very similar to the 2001 Census where 45% of seniors lived only with a spouse or common-law partner, 27% lived alone, 18% resided with their children or grandchildren (with or without their spouse present), 7% were in an institution and 3% lived with others (relatives or non-relatives). The current mean (average) number of persons in each Atlantic senior's household is 1.9.

Between 1999 and 2001 in Canada, of seniors who moved, 43% downsized to a residence with fewer bedrooms. Another 38% moved to a home with the same number of bedrooms and the remaining 20% moved up in size to a place with more bedrooms (Lin, 2005). When we look at the current number of bedrooms in Atlantic Canadian seniors' dwellings we find that 46.6% have two bedrooms or less.

TABLE 9 Number of bedrooms in dwelling

(n=1680)

bed-sitting room/ bachelor apt	.8
1	11.1
2	34.7
3	37.1
4	13.2
5	2.6
6	.4
7	.1
Total	100.0

Theme 2

Current dwellings of seniors and how well they meet the needs of their residents

Key Points

- While indicating that their current dwelling meets their needs, Atlantic Canada's seniors identified a number of areas of safety concern, particularly with regard to windows and entrances.
- Almost one-third had made some form of modification to their home to make it more accessible and another 23.5% had considered making such modifications.
- Two of five respondents identified the need to make energy improvements.
- Awareness of provincial funding programs to assist with such modifications was 43.9%, indicating the need for building more awareness of these programs.

Does their dwelling meet their needs?

Atlantic Canadian seniors resoundingly indicate that their current dwelling meets their needs, with PEI residents showing the highest satisfaction as indicated in the following table:

TABLE 10 Dwelling meets needs

	Atlantic	NS	NB	NL	PE
Meets needs	91.9	90.1	92.5	90.0	94.7
	n=1640	n=362	n=509	n=390	n=379

At first glance this expression of satisfaction appears very high but when we inquired into the areas of their homes that they believe pose safety or accessibility problems, we found that a number of structural issues were identified as causing difficulties for our seniors, as indicated in the following table:

TABLE 11 Areas identified as posing safety/accessibility problems

	NO	YES	
Windows	76.5	23.5	n=1665
Entrance area	82.4	17.6	n=1680
Storage spaces	83.9	16.1	n=1675
Layout of the bathroom	86.1	13.9	n=1679
Inside stairs	87.5	12.5	n=1667
Layout of the kitchen	95.0	5.0	n=1685
Overall dwelling design	89.0	11.0	n=1659
Bedroom	92.2	7.8	n=1679

For each area of safety concern, we asked respondents to identify specific issues. For example, when windows were identified as a safety problem, respondents indicated that their windows were in need of replacement (78.6%). For the entrance area, 74.9% reported that icy steps were the major concern.

We also asked about the need for repairs and over half of our sample (50.1%) indicated the need for some repair, with 21.1% of these identified as major repairs. This included corroded pipes, damaged electrical wiring, sagging floors, bulging walls, damp, crumbling foundations, and rotting porches or steps.

Of those respondents indicating a need for some level of repair, the first table shows the percent of homes built in a given time period and the level of repair these homeowners felt their home required. Multiple replies were allowed so that the rows do not total 100%. The table reflects the expected increase in repair requirements with dwelling age.

TABLE 12 Repairs needed grouped by year home was built

(n=782)	Regular repairs needed	Minor repairs needed	Some major repairs needed
Before 1946	72.2	49.2	27.8
1946–1955	79.1	34.9	22.1
1956–1965	80.2	47.7	21.6
1966–1975	80.1	34.0	19.9
1976–1985	74.8	47.9	17.6
1986–1995	81.5	25.9	13.6
1996–2005	72.5	40.0	10.0
2006	0.0	100.0	0.0

The second table looks at the same question, but indicates the level of repair as a percentage of all respondents indicating that same level of repair as being needed, again highlighting the need for repair for aging dwellings. It also illustrates the apparent greater need for repair at around the point when the dwelling is 40 years old.

TABLE 13 Repairs needed as compared to all dwellings

(n=782)	Regular repairs needed	Minor repairs needed	Some major repairs needed
Before 1946	22.5	28.4	32.1
1946-1955	11.3	9.3	11.7
1956-1965	14.8	16.4	14.8
1966-1975	20.8	16.4	19.1
1976-1985	14.8	17.6	13.0
1986-1995	11.0	6.5	6.8
1996-2005	4.8	4.9	2.5
2006	0.0	0.6	0.0
Total	100.0	100.0	100.0

Dwelling Modifications

Slightly over thirty percent (30.7%) of respondents indicated that they had modified their dwelling in some way to make it more accessible, while another 23.5% indicated that they have considered such modifications.

The modifications that were actually made included:

TABLE 14 Modifications made to the dwelling

(n=509)	
Installed grab bars in bathrooms	66.2
Modified bathtub and/or installed shower	30.6
Added hand railings to stairs	37.1
Added ramp or stair-lift	12.8
Modified kitchen cupboards and counters	9.2
Relocated bedrooms to main floor	13.6
Installed bathroom on the main floor	13.6

We also asked about the need to make improvements in their dwelling's energy efficiency. As illustrated by the following table, 57.2% of the sample indicated such improvements were not necessary, while almost half (47.6%) indicated that major repairs were needed to improve energy efficiency.

TABLE 15 Energy efficiency improvements needed

	Atlantic	NS	NB	NL	PE	
No repairs needed	57.2	59.2	57.4	54.6	57.7	n=1540
Minor repairs needed	69.4	66.4	67.9	73.7	69.2	n=652
Major repairs needed	47.6	50.0	50.2	43.6	46.5	n=652

Minor improvements included those such as adding insulation or blocking drafts, while major improvements included replacing windows or heating systems.

Knowledge of Provincial Financial Assistance Programs

We asked if our respondents were aware of programs that provide financial assistance to seniors with low income to help them rehabilitate, restore, or repair their dwellings. As indicated in the following table, awareness of such programs is lowest in New Brunswick, and overall in Atlantic Canada, only 43.9% of our seniors are aware of these programs.

TABLE 16 Awareness of financial assistance for dwelling repair

	Atlantic	NS	NB	NL	PE
NO	56.1	53.0	62.0	58.7	48.3
YES	43.9	47.0	38.0	41.3	51.7
	n=1645	n=353	n=511	n=402	n=379

We then asked those that were aware of such programs if they had received financial assistance from these programs and only 15.3% had done so.

Theme 3

Future housing plans of our seniors

Key Points

- Very few seniors have made plans for a future move.
- Those that have thought about it indicate that downsizing and having access to better or more suitable housing are the primary motivators.
- Our seniors want to stay in the area where they now live and if they did move, they would like it to be to some form of seniors' housing/apartments.
- The primary motivator for actually making a move is to be near family and friends.
- When asked about the suitability/attractiveness of various options for the future, garden or "granny suites" topped the list.
- There is a strong preference for "senior's only" housing developments, with only 1 in 5 respondents indicating any interest in intergenerational housing.

Moving

As noted in the introduction to this report, where and how we live is a reflection of where we are in our lifecourse. An estimated 240,000 seniors made a residential move between 1999 and 2001 in Canada. But while seniors accounted for 17% of the population aged 25 years and older, they were under-represented among actual movers at 9% (Lin, 2005). From our survey, we identified those seniors that had moved in the past 3 years and found that 10.6% indicated they had moved in the period between March 2003 and March 2007.

TABLE 17 Length of time in current dwelling

	Atlantic	NS	NB	NL	PE
Less than 3 years	10.6	11.1	11.2	9.7	10.2
	n=1649	n=367	n=508	n=393	n=381

We asked our seniors about their expectations and future plans in relation to moving from where they currently dwell. Not surprisingly, few indicated any plans to move, as only 12.6% responded positively that they did have such plans. There was some variation by province, with the lowest intent to move in Newfoundland and Labrador; and the highest in PEI.

TABLE 18 Plans to move

	Atlantic	NS	NB	NL	PE
Plan to move	12.6	12.4	13.1	10.9	13.8
	n=204	n=44	n=66	n=42	n=52

Of those planning to move, only 22.8% indicated that they plan to do so in the next 12 months. The majority (62.3%) indicated that these moving plans were 6 to 10 years in the future.

The attachment to the home can be very strong. Those who have reached old age will often stay in a house that is impractical or unsafe against the advice of family, care workers and friends because it is their home. The attachment to the home has been known to override rational thought and can leave the senior in a dysfunctional relationship both with their home and with their family. An excerpt from Frank (2002), illustrates this feeling:

> My conscience tells me if I don't do what they (my family) want me to do, maybe I will make them think I am not well. [Then] I have the feeling that it is my fault, so I give in. I fought ten years and I told my daughter and I told everybody, "Don't ever let them put me in a home" – and here I am! So I have nothing to say. Life did it to me. (pg. 102)

Reasons for moving

We asked those seniors who indicated that they plan to move to identify their reasons. As indicated in table 19 the results were as follows:

TABLE 19 Reasons for planning to move in future

(n=202)

50.0	downsizing from a larger dwelling to a smaller one
41.1	to access better/more suitable housing
38.9	difficulty maintaining home or garden
36.1	decline in personal health
24.8	to be closer to family/friends
23.8	to access better/more health care services
23.3	cost of living too high
22.8	decline in health of spouse/partner

21.8	difficult to get around (e.g., too many stairs)
16.3	to access better/more recreational facilities/services
16.3	to have better access to transportation
15.3	death of spouse/partner
10.4	climate and natural environment
3.5	return to my roots
2.0	to be closer to spouse/partner
1.0	employment

Where would they move?

Respondents that had indicated intent to move also told us where they planned to move as indicated in the following table:

TABLE 20 Where do seniors plan to move to?

	Atlantic	NS	NB	NL	PE
Same community	35.9	35.7	34.4	31.0	41.5
Area surrounding this community	19.2	23.8	19.7	16.7	17.0
Another community in the region	16.7	11.9	19.7	21.4	13.2
Elsewhere in the province	12.6	11.9	4.9	19.0	17.0
Elsewhere in Canada	8.1	7.1	8.2	4.8	11.3
	n=198	n=42	n=61	n=42	n=53

The expectation by the majority (55.1%) is that they will stay in the area surrounding the same location in which they now live in. This compares with the overall Canadian situation where, when senior Canadians moved, three-quarters of them stayed within 50 kilometres of their former residence (Frank, 2002).

Among the reasons identified for choosing the location for their future move, the most frequently mentioned were the desire to remain close to family and friends (58.3%) followed by the desire to find better or more suitable housing (39.7%). Other reasons for selecting the planned location for their move included:

TABLE 21 Reasons identified for choosing future move location

	Atlantic	NS	NB	NL	PE
Family and friends live there	58.3	54.8	58.1	54.8	64.2
Climate and natural environment	13.5	7.1	21.0	11.6	11.3
More or better health care services there	28.1	26.2	19.4	40.5	30.2
More or better recreation facilities and services there	16.1	16.7	12.9	11.9	22.6
Better or more suitable housing there	39.7	28.6	37.1	50.0	43.4
Lower cost of living	28.6	28.6	30.6	31.0	24.5
Easier access to shopping, banks, etc.	34.2	21.4	32.3	40.5	41.5
Better transportation there	22.2	16.7	18.0	28.6	26.4
	n=199	n=42	n=62	n=42	n=53

What type or types of accommodation will they be seeking?

Again, among those respondents indicating the intent to move, they indicated what type of accommodation they expected to be seeking in the future when they did move. As seen in the following table, the majority expect to be looking for senior citizen's housing.

TABLE 22 Types of accommodation being sought in future

(n=205)

53.4	senior citizens' housing
41.0	apartment
26.8	single-family detached house
18.0	semi-detached, duplex, townhouse, rowhouse
10.7	mobile home
10.2	nursing or special care home

Among the types of accommodation that our senior respondents were considering for their future move, senior citizens' housing was the primary choice, with 53.4% indicating this as an option. Second place fell to apartments, with 41% considering this as an option and in third place, single-family detached houses, with 26.8% identifying this as an option.

In another series of questions, we asked respondents to consider their preferences if the situation was such that they could no longer maintain their

own home and had to move into retirement housing or a care facility. Their preferences were as indicated in the following table:

TABLE 23 Preference of location of future dwelling

(n=1628)

Remain in community	74.0
Move elsewhere in region	12.3
Move elsewhere in province	5.5
Move elsewhere in Canada	2.9
Other	5.2
Total	100.0

Of the respondents, 43.5% indicated that they would like that facility to be in the city/town centre.

Again, being near relatives and friends (80.4% of respondents) or being familiar with the location (72.1%), as well as proximity to support or care facilities (57.1%) were identified as reasons for the choice of location - in this case, where that retirement housing or care facility might be located.

When asked what their ideal living arrangement would be, the prefered choice was to stay where they already are (26.5%). Various other options were noted as follows:

TABLE 24 Ideal future living arrangement – all options

(n=1019)

Where they are now	26.5
Apartment/condo	17.5
Where they are now with help	6.4
House	5.2
Garden home	2.4
Independent	3.3
Smaller dwelling	6.1
With or near family/friends	3.6
Don't know	1.3
Other	16.6
Long-term care	1.0
Accessible	4.6
Seniors housing/congregate housing	5.6
Total	100.0

When we combine those that indicated that they want to stay where they are now with those that indicated that they would also stay where they are now but with help we have the results as indicated in table 25. As can be seen in the table, Newfoundland and Labrador has the highest percent that fall into this group.

TABLE 25 Ideal future living arrangement – combined choices

	Atlantic	NS	NB	NL	PE
Where they are now including with help	33.5	33.8	32.5	37.4	30.9
Apartment/condo	20.1	17.6	21.4	16.7	24.0
	n=1019	n=210	n=350	n=227	n=233

Feelings about various housing options

Our respondents were presented with descriptions of a variety of housing options to consider and then asked to indicate if they would seriously consider that option for themselves. The choices ranged from a more traditional detached single-family dwelling to sheltered and congregate housing to Abbeyfield housing and "granny flats."

The most popular option was to move to a garden suite or "granny flat," which was positively considered by 21.1% of respondents. The other choices and their level of acceptance were:

- Garden or granny suite 21.1% – Garden suites are small self-contained houses that are placed on the same lot as the home of a close family member. They are designed for seniors who want to live close to their family while maintaining their independence and privacy. Most suites have one bedroom and a living room, kitchen, and bathroom, as well as storage and laundry facilities. The suites are not intended as permanent additions to the lots. They are usually factory-built and can be quickly erected and easily removed when no longer needed.
- Sheltered housing 19% – Sheltered housing is a type of seniors' housing that consists of self-contained apartments or small one-story homes that are clustered in groups of 20 to 50 dwelling units. A key feature is that each unit is linked to the project manager by an alarm system.
- Special retirement housing 17.8% – This is a housing development specially built for seniors but not a nursing home.
- Congregate housing 14.5% – Congregate housing differs from sheltered

housing primarily in terms of the number of services provided. Residents have their own private apartments, which usually include a kitchen so they can prepare light meals. They eat main meals in a communal dining room. Usually, housekeeping and personal care services are included as part of the accommodation package.

- Live-in housekeeper 8.6%
- Buy a smaller single-family detached house 7.7%
- Mobile home or manufactured housing in a planned retirement community 5.4%
- Abbeyfield housing 3.9% – In an Abbeyfield House, people (usually 7 to 10) move into a large house where they each have a private room and share one or more meals a day, as well as the services of a housekeeper, in a family atmosphere. The house is acquired and operated by a non-profit society, but the residents share in the operation of the house.
- Shares in a co-operative housing development 2.8% – Purchasing shares in co-operative housing is an option of interest to some older people. Members of a co-op share in both the ownership and the management of the housing developments they live in. After initially buying shares, they make monthly payments that cover part of the building's mortgage, interest, taxes, and operating costs. This payment gives them the right to occupy a specific dwelling unit. When they leave, their shares are redeemed by the co-op.

The majority of seniors have not heard about alternative forms of housing or housing programs. The exception was reverse mortgages, where 67.6% of respondents had some awareness of these programs.

The final question asked whether respondents would prefer to live in a development that was for "seniors only" or in one where age groups were mixed. The responses were as indicated in the following table:

TABLE 26 Preferred type of housing arrangement in the future

(n=1395)	For seniors only	For seniors and middle-aged adults	For people of all ages, including families with children
Lowest thru 64	23.3	50.0	26.7
65 to 69	31.2	46.0	22.5
70-74	31.8	46.4	21.5
75-79	38.4	43.5	17.8
80-84	44.7	40.9	14.4
85 thru highest	54.0	35.6	10.3

It is interesting to note that 80.1% of respondents would prefer to live in a housing development focused on adults who are middle-aged or older, and that this preference for "seniors only" living arrangements increases with age.

Theme 4

How transportation issues impact our seniors

Key Points

- While seniors have voiced strong concerns about transportation accessibility, 78.5% of our respondents reported that they never have a problem getting where they want to go.
- This matches the overall percentage of seniors (78.8%) that reported they are still driving.
- It is the remaining 21.6% of seniors that face transportation challenges, although most found rides with friends and neighbours.
- Actually having someone to ask is a problem for some.
- Even when there is someone, 1 in 3 indicated they do not like asking for a ride

Transportation

In preparing the "Strategy for Positive Aging in Nova Scotia," it was noted by the authors that "transportation emerged as the most consistently presented topic at the Task Force on Aging meetings" (page 112). Seniors value their mobility, with 78.8% of our seniors indicating that they still drive.

TABLE 27 Still able to drive car

	Atlantic	NS	NB	NL	PE
NO	21.2	26.4	16.8	27.2	15.9
YES	78.8	73.6	83.2	72.8	84.1
	n=1686	n=375	n=517	n=404	n=390

As indicated in the following table, the percentage of seniors that drive declines with age. However, it is interesting to note that by the time our seniors reach 95 years of age, a surprising 25% indicate that they do still drive.

TABLE 28 Driving now

(n=1649)	Age of respondent recorded				
	Lowest–64	65–74	75–84	85–94	95–highest
Percent still driving	86.7	85.5	73.1	43.0	25.0

When asked if they have any problems driving a car, 12.7% of Atlantic Canadian seniors indicated that they do.

The issue of transportation impacts almost all aspects of senior life from picking up the groceries or simply visiting family and friends to getting to the doctor. We began this area of inquiry by asking our seniors where they normally go for a range of activities as indicated in the following table:

TABLE 29 Where seniors go to receive services and how often

Type of Service	Never go	Only in my community	Mostly in my community	Mostly outside my community	Both in and outside of community
Family doctor	1.0	44.4	23.1	31.2	0.3
Specialist physician	6.3	20.7	15.1	57.9	0.4
Post office	4.6	68.1	19.0	8.0	0.4
Drug store	1.4	54.9	17.3	26.3	0.1
Grocery store	1.3	48.4	24.3	25.5	0.4
Seniors' centre	61.8	20.6	8.8	8.6	0.2
Bank	2.3	53.9	15.3	28.4	0.1
Church	10.8	58.2	20.7	10.0	0.2
Visit friends	3.5	23.0	52.2	18.2	3.2
Visit family	2.4	18.3	33.2	43.2	3.0
Recreation facilities	30.6	29.4	25.7	13.3	1.0

We then asked our respondents how they get to those places listed in the table above in good and bad weather and, not surprisingly, we found the expected decline in going out at all or opting to drive one's self in bad weather. The table below provides an illustrative example: when asked about getting to the family doctor in good and bad weather, senior respondents reported the following transportation choices:

TABLE 30 How seniors get to the doctor in good and bad weather

	Don't go out	Walk	Drive myself	Spouse/ partner drives	Others drive	Taxi	Regular bus	Seniors' accessibility bus
Good weather	1.1	5.8	70.1	19.7	13.7	4.7	1.2	0.3
Bad weather	16.5	2	51.1	20.3	16	6.4	1.1	0.1

Similar results were indicated in travel to other destinations.

Getting where they want to go

Given that the issue of transportation is high on the list of concerns raised by seniors, we asked if our seniors have difficulty getting where they want to go at the times they need to. As seen in the following table, 78.5% indicated that they never have a problem and a further 19% only occasionally have a problem getting where they need to go when they want to:

TABLE 31 Difficulties getting where you want, when you want

	Atlantic	NS	NB	NL	PE
Never	78.5	74.9	79.4	77.6	81.7
Occasionally	19.0	21.0	17.8	20.4	17.0
Fairly often	2.1	3.0	2.0	2.0	1.3
Very often	0.5	1.1	0.8	0.0	0.0
	n=1651	n=366	n=505	n=398	n=382

The reasons given by those who indicated that they have a difficult time getting where they want to go when they need to, are shown in the table below:

TABLE 32 Reasons given for having difficulty getting where they want to go

(n=360)	Percent indicating a difficulty
Don't like asking for a ride	34.4
Regular driver not available	30.6
Can't afford to pay for rides	13.1
Need assistance getting in and out of vehicle	9.2
Don't know anyone to ask for a ride	6.4

Transportation improvements

When asked what improvements in transportation would help seniors to get around in their community, the most frequently mentioned improvements, as indicated in the following table, were:

TABLE 33 Suggested transportation improvements

	Atlantic	NS	NB	NL	PE
Regular bus service on weekends	17.7	16.2	17.5	16.2	20.6
Regular bus service to larger centres	30.5	27.5	27.3	27.5	40.3
Regular bus service around town	22.2	18.8	21.9	21.4	26.3
Door-to-door transportation service for seniors	45.0	52.4	46.3	45.8	36.0
More frequent service from existing bus system	13.2	14.2	13.2	10.1	15.1
	n=1465	n=308	n=462	n=345	n=350

Theme 5

Activities of everyday living and health

Key Points

- As we age, health plays an ever-increasing role in our housing decisions.
- Although a high percentage of respondents rated their overall health as being "good" to "excellent," it is important to consider that almost one-third of our respondents indicated that their health status was fair to very poor, with arthritis as the most frequently identified long-term health condition.
- The greatest challenge of everyday living identified by our seniors was going up or down stairs, followed by doing chores around the home.

Health

As seniors age, health becomes a much more important factor in the decision-making process, especially when considering whether or not to leave or stay in one's home. As reported by Lewis (2006), while only 1.1% of people younger than 30 years of age consider health when making a housing decision, 42.3% of those 85 years of age or older *do* consider health when making a housing decision. In our survey, overall 36.1% of Atlantic Canadian seniors identified health as one of the reasons they planned to move in the future.

Taking this theme a step further, we asked our senior respondents to rate their own health. As can be seen in the table below, a strong 67.8% indicated that they felt their overall health was good to excellent.

TABLE 34 Current self-reported health status

	Atlantic	NS	NB	NL	PE
Very poor	1.9	2.4	1.2	3.0	1.0
Poor	4.2	4.3	4.1	5.7	2.6
Fair	26.1	29.0	25.2	26.4	24.2
Good	56.8	55.8	56.1	54.1	61.6
Excellent	11.0	8.4	13.4	10.7	10.6
	n=1673	n=369	n=515	n=401	n=388

Health status change in the last year and five years

We also asked our respondents if their health status had changed. As the following table indicates, 19.9% stated that there had been such a change in the last year. It is interesting to note that the number of respondents reporting a health status change more than doubles to 44.2% of the sample when respondents were asked if their health status had changed in the last 5 years.

TABLE 35 Health status change

	Atlantic	NS	NB	NL	PE	
Change in the last year	19.9	19.4	23.1	21.2	14.9	n=1661
Change in the last 5 years	44.2	44.6	46.6	41.9	43.0	n=1632

Chronic Health Conditions

We asked about long-term health conditions that are expected to last or have already lasted 6 months or more, and that have been diagnosed by a health professional. These health conditions, arthritis, for example, may have a direct link to an individual's housing needs because the condition may limit that person's ability to perform everyday activities such as opening windows or doors or climbing stairs.

The following table indicates several types of chronic health conditions and the percentage of respondents reporting that they have experienced or have been diagnosed with any such condition:

TABLE 36 Chronic health conditions

	YES	
Have you ever suffered a stroke?	7.9	n=1675
Have you ever had a heart attack or been diagnosed with heart disease?	26.0	n=1683
Have you been diagnosed with diabetes?	20.3	n=1682
Have you been diagnosed with arthritis?	52.8	n=1675
Have you been diagnosed with Alzheimer's disease or any other dementia?	1.7	n=1670
Have you been diagnosed with a mood disorder such as depression, bipolar disorder, manic depression, mania, or dysthymia (prolonged sadness)?	8.4	n=1676
Have you been diagnosed with an anxiety disorder such as a phobia, obsessive-compulsive disorder, or a panic disorder?	4.1	n=1675
Do you have autism or any other developmental disorder such as Down syndrome, Asperger syndrome, or Rett syndrome?	0.7	n=1669

We also asked our respondents whether or not they have difficulty with activities of everyday living. In this vein, our senior respondents were asked to tell us about the day-to-day challenges they face. Not surprisingly, for those who reported having a "fairly" or "very serious" problem, going up or down stairs and doing chores around the house were the activities that posed the greatest challenges. It is interesting to note, however, that the number of respondents reporting fairly or very serious difficulty with any of the everyday activities was surprisingly small, particularly when compared with the percentages of those who reported not having any problem at all, as indicated in the following table:

TABLE 37 Difficulties experienced with personal care and daily living actvities

	No problem	Minor problem	Fairly serious problem	Very serious problem	
Going up or down stairs	72.3	19.0	5.5	3.2	n=1671
Doing chores around your dwelling	72.3	17.8	6.2	3.8	n=1671
Hearing	76.6	18.1	4.4	0.8	n=1642
Getting around outside your dwelling	82.1	11.5	4.4	2.0	n=1673
Seeing (even when wearing glasses)	82.6	13.7	3.3	0.5	n=1669
Taking a bath or shower	85.8	9.2	3.5	1.6	n=1679
Getting in or out of bed or a chair	87.1	10.6	1.4	0.9	n=1688
Moving about your dwelling	90.8	6.6	1.8	0.8	n=1677
Getting on and off the toilet	91.8	6.0	1.3	0.8	n=1691

The prevalence of arthritis climbs with age. While an estimated 200,000 Canadians aged 25 to 34 have some form of arthritis, more than four times that number are affected over age 55. To put it another way, 31% of women and 19% of Canadian men 40 and older have arthritis. By age 80, 57% of women and 40% of men are living with the condition (Arthoscope, 2004). This survey found that 52.8% of Atlantic seniors reported that they have been diagnosed with arthritis. A study by Tak (2006) concluded that the disability and pain associated with arthritis make it difficult for elders to conduct activities of independent daily living and cause many physical and emotional stresses.

Theme 6

Current support service use and needs of Atlantic seniors

Key Points

- By and large our seniors are willing to pay for a range of services that will help them age-in-place.
- Those tasks that require the greatest physical exertion are the ones most identified as requiring someone else to do them or needing help to do them.
- The number-one source of that assistance is other family members.

Support services

The *Strategy for Positive Aging in Nova Scotia* stated that

> Seniors prefer to live independently and remain in their own home for as long as possible. Aging in place promotes self-sufficiency, encourages interdependence between friends, family members and neighbours in the community, offsets social isolation and reduces the need for professional support. Maintaining friendships, familiar shopping, entertainment, and community supports enhance quality of life, personal control, and dignity. (p.98)

One of the core components of the ability to remain in an existing home as one ages is the availability of support services in the local community. We asked our seniors about a range of support services, if they currently used such services, and who provided them. Almost 35% have help with seasonal or outside maintenance as indicated in the following table:

TABLE 38 Use of support services and who might provide these in the future

Type of support service	Respondent receives help with service	Who might help respondent with service in the future? (1st choice)
Seasonal yard work or outside maintenance	34.9	Family 57.8
Visit regularly	25.7	Family 72.0
Repairs around dwelling	25.0	Family 56.6
Heavy or spring cleaning	24.0	Family 57.6
Drives when needed	23.3	Family 74.5
Everyday cleaning	16.7	Family 59.5
Grocery shopping and errands	13.7	Family 77.7
Cooking	8.9	Friend 73.4
Taking a bath or shower	4.1	Family 59.2
In-home nursing care	2.7	Paid agency 56.3
Hot meals delivered to the door	0.8	Family 60.8

With the exception of in-home nursing care and help with cooking, family members were identified as the providers of this help.

For those who did not currently receive help with the identified tasks, we asked them to tell us if they thought they needed help and if they would pay for that help. Help in and around their dwellings with tasks like repairs, cleaning, and maintenance topped the list of support services identified as needed.

TABLE 39 Support services that could be required and expectations of paying for these

Type of support service	Respondents who need help with service	Respondents who would pay for service
Repairs around dwelling	21.7	76.0
Heavy or spring cleaning	16.9	81.5
Seasonal yard work or outside maintenance	13.4	71.3
Drives when needed	5.4	70.1
Everyday cleaning	3.9	80.4
Grocery shopping and errands	3.6	68.1
Visit regularly	3.0	52.2
Cooking	2.4	66.3
Taking a bath or shower	1.7	68.1
Hot meals delivered to the door	1.3	83.9
In-home nursing care	1.1	71.0

It is clear that the family is the main provider for almost all of the services listed in the survey, with the exception of in-home nursing care and help with cooking.

We asked about the use of emergency response services and found that 6.4% indicated current use of such a system.

TABLE 40 Has an emergency response system

	Atlantic	NS	NB	NL	PE
NO	93.6	90.4	93.6	95.6	94.4
YES	6.4	9.6	6.4	4.4	5.6
	n=1615	n=354	n=499	n=390	n=372

When asked if emergency response systems were available, the responses were as follows:

TABLE 41 Availability of emergency response system in local area

	Atlantic	NS	NB	NL	PE	
Respondent has emergency response system	6.4	9.6	6.4	4.4	5.6	n=1615
There is emergency response system available in respondents' community	67.3	74.8	76.1	40.6	76.7	n=1159
Respondent would use emergency response system if it was available in their community	73.8	70.8	70.1	81.2	73.6	n=1151

We then asked respondents if they would use such a service if it were available and 73.8% of the respondents indicated that they would.

Theme 7

Current social supports and needs of our seniors

Key Points

- The main source of social support is family members.
- In addition, Atlantic Canadian seniors are heavily involved as volunteers, with almost half (48.5%) indicating some kind of volunteer activity.

Social Supports

Support comes in many ways and from a variety of sources. We tend to seek places to live that we think will support us to lead a full life. Having someone to listen to you, to show you love and affection, or even to confide in and share problems, all enhance the quality of life and play a role in our housing decisions. We asked our seniors if they have such social supports and who provides them. The answers are shown in the following table:

TABLE 42 Availabilty of social support

Type of social support	Degree of availability	
	All of the time	None of the time
Someone who shows you love and affection	54.6	5.0
Someone who hugs you	37.4	8.4
Someone to confide in or talk to about yourself or your problems	36.9	8.2
Someone to give you advice about a crisis	34.7	10.8
Someone to have a good time with	33.0	5.5
Someone to share your most private worries and fears with	32.3	12.3
Someone to turn to for suggestions about how to deal with a personal problem	32.2	11.6
Someone you can count on to listen to you when you need to talk	32.2	16.3
Someone to do something enjoyable with	31.9	4.0
Someone to get together with for relaxation	28.8	5.7
Someone whose advice you really want	27.6	9.6
Someone to do things with to help get your mind off things	23.3	10.7

In every case, our respondents reported that family are the most frequent providers of support, ranging from a high of 59.8% of seniors indicating that support in the form of someone to share their most private worries and fears with, to a low of 40.7% who indicated family were there to listen to them when they needed to talk

Participation in Seniors Programs/Volunteering

We also asked our seniors about their level of participation in activities outside the home. The degree of participation by our seniors in local community programs was only 12%.

TABLE 43 Participation in local community programs

	Atlantic	NS	NB	NL	PE	
Respondent attends a seniors' centre in their community	12.0	9.9	15.4	9.4	12.2	n=1642
There is a seniors' centre in respondents' community	63.8	59.6	69.5	59.1	65.9	n=1275
Respondent would attend seniors' centre if it was available in their community	38.3	40.3	35.6	40.5	37.5	n=1000

A very small number of respondents (0.7%) indicated that they attended an adult daycare centre for seniors who require or want more health-related services than those provided at a typical seniors' centre.

Of those who indicated they did not attend an adult daycare centre for seniors, only 18.5% indicated that such a service was available in their community. Over one-third of respondents indicated that they would be interested in attending an adult daycare centre for seniors if one was available in their community.

TABLE 44 Adult daycare use, availability and interest

	Atlantic	NS	NB	NL	PE	
Respondent attends adult daycare	0.7	0.3	0.6	1.3	0.5	n=1630
There is an adult daycare available in respondent's community	18.5	14.6	16.8	18.4	24.8	n=1209
Respondent would use adult daycare if it was available in their community	34.1	30.4	34.6	39.0	32.0	n=1204

We found that almost half of our respondents (47.4%) had volunteered in the past year, with 79.5% doing some volunteer activity at least once a month.

TABLE 45 Volunteers at least once a year

	Atlantic	NS	NB	NL	PE
NO	52.5	60.2	48.3	55.0	48.2
YES	47.4	39.8	51.4	45.0	51.8
	n=1664	n=363	n=515	n=400	n=386

TABLE 46 Frequency of volunteer activity

(n=812)	Percent	Cumulative Percent
At least once a week	35.5	35.5
At least once a month	44.0	79.4
At least 3 or 4 times a year	13.7	93.1
At least once a year	4.6	97.7
Not at all	2.3	100.0
Total	100.0	

Theme 8

Current income, financial status and needs of our seniors

Key Points

- Almost half of our respondents reported less than $30,000 income per year and a significant percentage of these individuals indicated that they spend more than 30% of their income on shelter costs.
- With 1 in 5 seniors spending 40% or more of their income on where they live, they are at risk and have a serious housing affordability problem.

Household Income

The total household income for 2006 as reported by our respondents was:

TABLE 47 Total household income

(n=1519)	Percent	Cumulative Percent
Less than $11,000	1.7	1.7
$11,000–$14,999	9.2	10.9
$15,000–$19,999	9.7	20.7
$20,000–$24,999	16.7	37.3
$25,000–$29,999	12.1	49.4
$30,000–$39,999	18.6	68.1
$40,000–$49,999	11.3	79.4
$50,000–$59,999	8.4	87.8
$60,000–$69,999	4.5	92.4
$70,000 or more	7.6	100.0
Total	100.0	

Almost half (49.4%) of our seniors reported having less than $30,000 per year total household income.

That income came from a variety of sources, including the Old Age Security Pension (96.6% received) and the Canada or Quebec Pension (84.6% received). Savings and investments played a role in 33.6% of respondent's income.

Acceptable housing is defined by the CMHC as *adequate and suitable shelter that can be obtained without spending 30% or more of before-tax household income:*

> Housing affordability problems refer to those households where 30% or more of household income is spent on shelter costs including rent, electricity, heating fuel, water or other municipal services, mortgage or loan payments for the dwelling, property taxes and condominium fees. If a senior lives in one of these households then they are said to have a housing affordability problem. (*Canadian Social Trends,* Fall 2005, Statistics Canada Catalogue No. 11-008, p. 2)

We asked our respondents to tell us what they estimated as the proportion of their household income that they spent on their shelter costs. Almost half (46.8%) of the respondents indicated that they spend more than 30% of household income on shelter.

TABLE 48 Percent of income spent on shelter costs

	Atlantic	NS	NB	NL	PE
Less than 30%	53.2	46.5	54.7	54.4	55.9
30-39%	27.1	33.3	24.8	24.5	27.4
40% or more	19.7	20.2	20.5	21.2	16.7
	n=1491	n=312	n=468	n=364	n=347

With 1 in 5 seniors spending 40% or more of their income on where they live, they are at risk of having a serious housing affordability problem.

We asked a number of questions about monthly and annual expenditures related to both rented and owned accommodation. The responses are averaged in the following table:

TABLE 49 Expenses associated with dwelling

Self-Reported Expenses	Renter	Owner
Monthly rental/co-op fee	*$694	
Monthly utility costs	$176	$189
Monthly telephone costs	$72	$135
Yearly home insurance costs	$270	$595
Property taxes last year	-	$1319
Estimated maintenance costs last year	-	$2416
Monthly mortgage payment	-	$170
Monthly condo fees	-	$20

*all numbers are rounded to nearest dollar

When asked if their income allows them to live adequately and still meet all of their housing-related costs, 18.5% said no. Further, when homeowners were asked if their finances would permit them to meet a major maintenance cost, such as replacing a furnace or roof, 34.4% reported that they would not be able to meet such an expense.

We wanted to know what housing options our seniors would consider, other than selling their homes, as a solution to financial, health, or other difficulties. The options presented to our respondents included the following:

- **Homesharing –** an arrangement where two or more unrelated people live together in a dwelling. Each person has a private space while sharing common areas such as a bathroom, kitchen, living room, and dining room**.** In most cases, one person owns the home, and the other pays rent or provides some services to the homeowner such as cooking, housekeeping, or gardening in exchange for free or reduced rent; 28.7% were aware of homesharing and 19.2% might consider it as an option.
- **A reverse mortgage –** a plan that allows seniors to have extra income by using their equity—the value they've built up in their homes. Under this plan, an older homeowner who takes out a mortgage on the home is guaranteed a monthly income for a fixed period of time (usually 10 to 15 years) or, in some plans, for life. The mortgage and interest do not have to be repaid until the term expires, the owner dies, or the home is sold; 67.6% were aware of reverse mortgages and 18.8% might consider this option.
- **Sale-leaseback –** an option that allows a person to sell some of the equity in their home while retaining occupancy rights. The individual can sell their home to an investor who immediately leases it back to the seller for life. The seller then becomes a renter in the home she or he has just sold; 13.8% said they might consider this option.
- **Life-hold estate –** an option that is similar to the sale-leaseback. In this case, however, the owner sells his/her home to an investor, but the title to the property does not transfer until the owner dies. Of our surveyed respondents, the same number as those who would consider the sale-leaseback—13.8%—indicated they might consider this option.
- **Property tax deferral –** in some provinces, older home owners can defer their property taxes until they die or the property is sold, at which time the taxes plus interest are due; 15.3% might consider this option.
- **Addition of a rental suite –** some older home owners adapt their existing home to put in a private suite that can be rented out, 16.1% indicated they might consider this option.

Next Steps

This report has presented an overview of the responses of Atlantic Canadian seniors to a survey about their current housing, social, and service support needs. It is the first step in exploring the extensive database of information created from these responses.

Because participants for the survey were selected randomly, some groups may not be as well-represented as others. We felt it was important that we heard from certain groups and communities in particular, such as Aboriginal elders, immigrant seniors, and older persons with disabilities, to ensure we represented their unique issues and concerns. To achieve this, 15 focus groups have been completed and the results of this qualitative portion of the research will be the subject of ASHRA's next report.

Additional copies of this report and an Executive Summary are available from the ASHRA website: www.ashra.ca or by emailing the ASHRA Project Coordinator at: Yvonne.daSilva@msvu.ca.

Appendix
Survey Methodology

Phase 2 was the field research (empirical) section of the Atlantic Seniors Housing Research Alliance (ASHRA) project. The Atlantic Seniors Housing and Support Services Survey was structured to gather information from a large number and diversity of adults over the age of 65, with the goal of learning more about their housing and support service needs, preferences, and ideas.

The overall purpose of the survey was to provide an understanding of the experiences and expectations of seniors and to gain knowledge about current services as follows:

(a) Assess how well current and planned housing polices and programs address seniors' needs,

(b) Determine how well existing housing options meet the needs of this population, and

(c) Examine innovative approaches and options emerging elsewhere in the world, and consider which of those approaches might be most appropriately developed in Atlantic Canada.

The methods used in Phase 2 evolved somewhat differently than were outlined in the original proposal to the Social Sciences and Humanities Research Council of Canada (SSHRC). The two main data collection methods—a survey and a series of focus groups—did not change, but the manner in which they were designed and implemented did require some adjustment.

To plan for survey implementation, the ASHRA team formed a decision-making body called the Survey Working Group (SWG).

1.1 Survey Working Group (SWG)

Work on the survey began in July of 2005, with a group of individuals who had expressed interest in being actively involved in the planning and other aspects of the survey process, thus forming the SWG. SWG members included a diverse group of co-investigators or collaborators, and a number of community partners from each province, as well as an evolving group of undergraduate and graduate students working with the project.

The SWG was responsible for guiding all aspects of the survey adaptation, design, implementation, data management, analysis, and reporting. When appropriate, feedback on aspects of the survey was solicited from other ASHRA committees, such as the Research Implementation Teams, the Research Management Team, and Provincial Stakeholder Groups.

1.2. CMHC Survey Adaptation

The ASHRA project was granted permission by the Canada Mortgage and Housing Corporation (CMHC) to use and adapt its 1998 questionnaire, "Seniors' Housing and Support Services Survey," for the purpose of developing the ASHRA *Seniors Housing and Support Services Survey.*

The original CMHC questionnaire was administered in one-on-one interviews. ASHRA originally planned to adapt the survey to (a) better reflect the SWG's interests in a determinants-of-health approach, and (b) create a research instrument conducive to having seniors fill it out themselves, potentially in groups assisted by community partners. As planning evolved, it was decided that it was important to ensure that the findings be representative; therefore, in the end, a random sample and mail-out survey approach was favoured.

Ultimately, the CMHC survey was adapted to

(a) better reflect the SWG's interests in a determinants-of-health approach;

(b) address the unique issues, languages, and cultures in Atlantic Canada; and

(c) be conducive to a mail-out survey where seniors would have to fill out the questionnaire themselves.

1.2.1. WORKING WITH STAKEHOLDERS

One of the first steps in the adaptation process was to circulate the original CMHC survey amongst the members of the Provincial Stakeholder Groups.

Throughout the survey adaptation and design process, versions of the ASHRA survey were brought along to stakeholder meetings, posted on the private side of the ASHRA website, and circulated by e-mail and regular mail. Stakeholder Group members contributed valuable comments and suggestions that helped to ensure the survey was accessible and relevant to the target population and that it addressed the questions that they—as representatives of community organizations, seniors groups, and government departments—wanted answered.

1.2.2. SURVEY DESIGN AND LAYOUT

Because the original CMHC survey had been developed for administration by an interviewer, it was not designed with self-administration or seniors in mind in terms of the lay-out, font size and text style, use of colour, icons, and other aspects of self-administered surveys. The SWG itself had little experience in this level of design, so graduate student, Matthew Neville, who has a background in planning, housing, and urban design, joined the team. Matthew's skill-set and familiarity with design principles and software programs were instrumental in the development of what the ASHRA survey actually looked like and the ease with which it flowed from one question to another.

Literature reviews that cover all aspects of communicating with seniors through survey design were completed, as well as evaluations of the structure and layout of other surveys. A key conclusion was the importance of removing as many skip patterns as possible.

1.2.3. PILOT STUDY

Having changed the content, structure, and implementation of the original CMHC questionnaire so substantially, it was decided that it was important to pilot-test the survey instrument and the process by which it would be administered with seniors in the region. Co-investigator, Dr. Lori Weeks at UPEI, supervised one of her students, Rachel MacDougall, in the development and implementation of the pilot study. The pilot participants included:

(a) 18 seniors on Prince Edward Island who were mailed the survey and then visited by the student researcher who administered a follow-up interview about their survey experience, and

(b) two focus groups of seniors on PEI (one Francophone and one Anglophone) who filled out the survey in a group setting and were then led in a discussion about their experience and impressions by a facilitator.

1.3. Ethical review process

In working with human subjects in Phase 2 of the ASHRA research, it was necessary for the project to obtain ethical approval from all of the universities where co-investigators were actively involved in the survey or focus group components. Mount Saint Vincent University (MSVU) is the primary research site; thus, ethics approval was applied for and obtained from the MSVU Research Ethics Board (UREB) prior to being sought at Memorial University of Newfoundland, the University of New Brunswick, and the University of Prince Edward Island.

Coordinating the ethics review process for a multi-site, multi-institutional research endeavour was a challenge. While all university ethics review boards are governed by the same Tri-Council Policy Statement, "Ethical Conduct for Research Involving Humans," each institution has its own board composed of faculty members with diverse backgrounds.

Divergent responses from these ethics boards resulted in delays of final approvals, thereby causing timelines to be pushed back. Having approval at the principal research site (MSVU) sped up the process at some of the other universities, less at others. Ultimately, approval was granted by all universities for the survey process as of September 2006, and April 2007 for the focus groups.

1.4. Sampling and recruitment procedures

In constructing the sample of survey participants, the objective was to have the Department of Health (DOH) in each province draw the sample from their medical services insurance databases and provide the ASHRA research team with a list of names, addresses, and phone numbers. Ultimately, due to different policies in each province, unique procedures had to be used in each case as described below.

In the proposal, the intended sample is described as a proportionate random sample of individuals 65 years of age and over, living independently (i.e., not living in an institutional setting such as a nursing home, prison, or hospital). The proportional representation within each provincial sample was to be built up from the actual proportions of males and females in each FSA falling within the two target age groups of 60-69 and 70-79. The intended composition of the sample changed over time as the Project Coordinator and other members of the SWG communicated with the departments of health and gained a better understanding of each organization's capacity and willingness to manipulate the sample. It was also decided that since representativeness was a priority, the less manipulation of the sample, the better.

1.4.1. POPULATION OF INTEREST

The population of interest for the survey was male and female individuals aged 65 and over living independ-

ently. The goal was to have n=601 completed surveys in each province for a total of n=2404 participants in all. The actual number of participants in the end was n=1704. However, two of the returned surveys had no provincial identification, so had to be dropped from the final survey total and eliminated from inclusion in the data analysis (i.e., final n=1702)

1.4.2. SAMPLING PROCEDURES

ASHRA requested samples of 2500 names from each Department of Health, hoping for a response rate of 25-30%.

The sampling proceeded as follows for each province:

Prince Edward Island:

The Department of Health in Prince Edward Island approved the ASHRA-proposed sampling procedure, namely, to draw the random sample of 2500 names, not including those living in an institutional setting. The list was forwarded to ASHRA in an Excel file that was then used to generate the mailing list of potential participants.

New Brunswick:

The Department of Health in New Brunswick was willing to draw the sample of 2500 names as requested for ASHRA; however, the Department was unable to release the names and addresses of the seniors on the list under their confidentiality policy. They also wanted to review all materials that would be sent out to the public to ensure that French translations were up to government standards and to include their own cover letter in the initial and follow-up mailings to assure recipients that the Province of New Brunswick endorsed the project. ASHRA shipped the sealed introductory letters to the Department of Health for mailing, using the list they prepared. Names and addresses were never released to the researchers.

Newfoundland and Labrador:

A similar procedure to that of New Brunswick was used in Newfoundland and Labrador. In this case, the Department of Health drew a sample of 3000 names then manually removed those living in an institutional setting, leaving a sample of 2897. The NL DOH did not officially request to review the materials to be sent out as in NB, but the Director of the Division of Aging and Seniors attended the NL Stakeholder Group meetings to ensure that the procedure and materials met the agency's standards.

Nova Scotia:

Early on, ASHRA was given indication by the NS DOH that a similar procedure for drawing the sample would be approved as it had been in NL and NB. Late in the planning stages, however, it was indicated that the Department was undergoing policy review in terms of how it deals with such requests from researchers, and while there was a great deal of support for the project, the Department was unable to draw a sample of Nova Scotians from its database due to its privacy restrictions. An alternate sampling strategy was developed, and a research firm (Focal Research) was hired to conduct a random-digit dialing process to recruit 600 seniors over the age of 65 and willing to be mailed and complete a questionnaire. While the sampling process was different from the other three provinces, it was a *random sample* of individuals (both listed and unlisted) in the NS telephone directory.

The following table details the number of surveys sent and the response rates for each of the four provinces as well as the overall response rate.

TABLE 50 Survey response rate

	Request to participate mailed	Returned/Useable Survey forms	Gross Response Rate
Prince Edward Island	2500	392	15.68%
New Brunswick	2500	522	20.88%
Newfoundland and Labrador	2897	406	14.01%
Nova Scotia	983	382	38.86%
No province recorded		-2	
Totals	8880	1702	19.19%

A total of 221 requests to participate or actual survey documents were returned as undeliverable or deceased. The 1702 surveys included in the analysis converted to a total response rate of 19.2%.

1.4.3. CONFIDENCE LEVEL AND INTERVAL

The total available sample of those 65 years of age and over in Atlantic Canada according to the Statistics Canada 2006 Census is 336,290 seniors. Using Raosoft's sample size calculator (www.raosoft.com/samplesize) we obtain the following confidence level and interval for this survey:

TABLE 51 Confidence level and interval

Confidence Level	99%
Confidence Interval	±3.5%

1.4.4. VALIDITY

The ASHRA respondents profile is slightly younger than that of the general population. Overall, survey sample validity was assessed by comparing the counts in each age cohort as follows:

1.4.5. RECRUITMENT OF PARTICIPANTS BY MAIL

The survey mail-out proceeded as follows for each province:

Prince Edward Island:

The PEI DOH drew the sample and forwarded an Excel spreadsheet with names, addresses, and phone numbers of 2500 seniors over the age of 65 and living independently. The ASHRA project office used the spreadsheet to create mailing labels. Each individual was mailed an information letter explaining the project and inviting their participation, as well as a reply form with a postage-paid envelope. Several weeks after the initial mailing, a follow-up letter was sent to those individuals on the list who had not returned reply forms. A package that included a survey, a cover letter, and a postage-paid envelope was sent to every individual who returned a reply form.

New Brunswick:

The NB DOH was unable to release the names and addresses of the sample population to ASHRA, so the recruitment materials were prepared by the ASHRA

TABLE 52 Analysis of validity

Total Stats Canada 2006 Census			Total ASHRA Survey			Variance
MEN			MEN			
	Count	Percent		Count	Percent	
65-69	48605	33	65-69	248	36	3%
70-74	38230	26	70-74	183	27	1%
75-79	27730	19	75-79	135	20	1%
80-84	18780	13	80-84	76	11	-2%
85+	12915	9	85+	41	6	-3%
Sum	146260	100	Sum	683	100%	0%
WOMEN			WOMEN			
	Count	Percent		Count	Percent	
65-69	50815	27	65-69	314	34	7%
70-74	42980	23	70-74	253	27	4%
75-79	36460	19	75-79	190	20	1%
80-84	29630	16	80-84	100	11	-5%
85+	30145	16	85+	80	9	-7%
Sum	190030	100	Sum	937	100	0%
Table total	336290		Table total	1620		

office and sent to the DOH for labeling and mailing. The NB packages included the addition of a letter of support from the NB government and were mailed in envelopes with the DOH's return address. Several weeks after the initial mailing, a follow-up letter was sent to everyone on the mailing list. A package with a survey, a cover letter, and a postage-paid envelope was sent to every individual who returned a reply form.

Newfoundland and Labrador:

Like NB, the NL DOH was unable to release the names and addresses of the sample population to ASHRA, so the recruitment materials were prepared by the ASHRA office and sent to the DOH for labeling and mailing. Several weeks after the initial mailing, a follow-up letter was sent to everyone on the mailing list. A package with a survey, a cover letter, and a postage-paid envelope was sent to every individual who returned a reply form. Also, due to ethical guidelines at Memorial University of Newfoundland (MUN), no names were permitted to leave NL. Therefore, the mail-out and receipt of reply forms and surveys had to be conducted by the ASHRA NL satellite office at the Patient Research Centre, which is located at MUN in St. John's.

Nova Scotia:

The aforementioned research company, Focal Research, produced a random list of 600 individuals over the age of 65, all of whom confirmed over the phone that they would be willing to complete the survey. A package with a survey, a cover letter, and a postage-paid envelope was sent to every one of the 600 individuals on the list.

1.4.6. SURVEY PROMOTION

ASHRA community partners were invaluable in the promotion of the survey within their communities, networks, organizations, and local news media. Students and staff at the ASHRA project office developed press releases, posters, letters, brochures, and newsletter articles that community partners used to raise awareness about the survey and encourage those who received a letter to participate. The excellent response rate we had for the survey was undoubtedly due in part to these efforts.

1.5. Survey implementation / Data management procedures

1.5.1. ASHRA PROJECT OFFICE

The bulk of the mailings (recruitment letters and surveys) were packaged and sent from the ASHRA office at MSVU in Halifax, Nova Scotia, where all completed surveys were received, sorted, and assigned anonymous tracking numbers. Basic demographics, questions, and other survey issues were also monitored from the ASHRA office at MSVU. The toll-free number for PEI, NB, and NS was forwarded to the telephone of the Project Coordinator at MSVU, so most of the inquiries from participants and the public were also fielded from ASHRA's Halifax office.

1.5.2. NL PATIENT RESEARCH CENTRE

Due to specific ethics protocols at MUN, ASHRA was obligated to ensure that the names of NL residents were not communicated/stored outside of NL. Therefore, a satellite ASHRA survey office was established at the Patient Research Centre (at MUN in St. John's), where ASHRA staff member and collaborator, Jackie McDonald, received reply forms, and mailed out and received completed surveys. Once the completed (anonymous) surveys had been received in NL, they were batched and shipped to the MSVU ASHRA office to be sorted and coded. Any follow-up phone calls were conducted from the NL Patient Research Centre.

1.5.3. MARITIME DATA CENTRE

The Maritime Data Centre (MDC), lead by Director (and ASHRA Co-Investigator), Dr. Janice Keefe, was contracted to do the survey data entry and analysis. Dr. Keefe was assisted by a graduate student Data Management Coordinator. Data was entered and cleaned from November 2006 to April 2007 by 7-10 student data entry clerks.

The MDC delivered a CD containing a cleaned and ready-to-use SPSS 13 data file and the supporting documentation (i.e., Code Book, Data Management Protocol, this methods document, reliability statistics, etc.) to each co-investigator and the MSVU project office. Co-Investigators will be responsible for maintaining the confidentiality of the data and for performing their own analysis. Community partners and stakeholders will be given the opportunity to explore the data for their own purposes with the support of a co-investigator.

1.5.4. COMMUNITY PARTNER ASSISTANTS (CPAS)

ASHRA community partners, collaborators, and stakeholders were instrumental in ensuring that seniors across the region were aware of the survey and the importance of participating.

In the original proposal, it was planned that community partners would conduct the recruitment of survey participants through their networks and facilitate the process of having participants actually fill out the questionnaire in seniors centres and legion halls in their communities. As the methodology changed to a random sampling and mail-out recruitment, community partners took on a different role.

The SWG was concerned that the survey process be made as accessible and simple as possible for the widest range of seniors possible, so it was decided that partners across the region would be trained to assist seniors in filling out the survey if they so required or desired. A training manual and video were developed to help familiarize community partner assistants (CPAs) with the different kinds of questions in the survey, provide them with answers to the questions that participants would be likely to ask, and offer a number of guidelines in terms of confidentiality and ethical research protocol. CPAs were also required to sign a CPA Confidentiality Agreement.

CPAs for the most part were members of the Stakeholder Groups or other ASHRA member organizations. When a request for assistance was received by the MSVU ASHRA office or at the Patient Research Centre in NL, staff worked to identify the most appropriate CPA (in terms of geography and availability) to respond to the request. Most requests for assistance were addressed by telephone, with only a handful requiring CPAs to travel to the home of the participant.

CPAs were reimbursed for all expenses incurred while helping the participants.

Ultimately, far fewer participants than expected availed of the option to have a CPA assist them. Many may have preferred to turn to family or friends if they required assistance. Those without support networks who would have required assistance to participate may have decided against taking part in the study altogether.

1.5.5. CONFIDENTIALITY, SECURITY, AND STORAGE

Sample confidentiality and storage:

For two out of the four provinces—NL and NB—ASHRA did not have access to the names and addresses of the individuals on the sample list—these remained confidential and in the hands of the Departments of Health in those provinces. For the PEI and NS lists, the Excel files were kept on a password-protected computer that could only be accessed by members of the ASHRA research team at the MSVU office. All returned mail with names and addresses was kept in a locked filing cabinet at the MSVU ASHRA offices located in the on-campus Nova Scotia Centre on Aging building at MSVU.

Reply form confidentiality and storage:

Returned reply forms from NS, NB, and PEI were kept in a locked filing cabinet at the NS Centre on Aging. For NL, the forms were kept in a locked filing cabinet at the Patient Research Centre in St. John's. Names of consenting participants were kept in an Excel file on a password-protected computer.

Survey confidentiality and storage:

All completed surveys were kept in filing boxes in a locked office in the NS Centre on Aging or, during data entry, in a locked filing cabinet in the MDC.

Survey anonymity:

No names or numbers linked to names were written on the surveys themselves, and surveys were stored separately from reply forms.

1.6. Data analysis and reporting

ASHRA co-investigators will proceed with analyses of the survey data based on their own research interests once they have obtained access to the SPSS data file through the MDC. In order to obtain access to the data, co-investigators are required to sign a "Data Access Agreement" and update the ASHRA project office as to the details of any planned publications, including details on the actual data they intend to use, the planned title of the publication, and an expected delivery date. The ASHRA project office will maintain a log of the status of these products, which will be updated regularly on the private side of the ASHRA website.

1.6.1 DATA ANALYSIS COLLABORATION – EXPLORING THE DATA INTERESTS OF STAKEHOLDERS AND PARTNERS

ASHRA's diverse team of community partners and stakeholders will be interested in accessing the survey data in order to perform analyses relevant to their own geographical communities and organizational interests. ASHRA co-investigators will be responsible for partnering with stakeholders in their province to arrange access to and assistance with analysing and interpreting the data, as well as ensuring the protocols are followed with respect to confidentiality. The ASHRA Project Coordinator will maintain a log of data access and analysis requests and will ensure that stakeholders are partnered with ASHRA co-investigators.

1.6.2. THE KNOWLEDGE TRANSFER WORKING GROUP

A working group of co-investigators, partners, and stakeholders will develop a Knowledge Transfer Plan. The KT Plan will outline a strategy for the dissemination of the survey findings, as well as findings from all other ASHRA research activities. The KT Plan will include the identification of the key messages ASHRA wants to communicate, and provide an action plan and timeline for the production of materials. Knowledge products will be developed based on those formats that will most effectively communicate those key messages to the range of audiences ASHRA hopes to engage.

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Notes