JOURNAL OF THE CENTRE DE RECHERCHE ET D'EXPERTISE EN GÉRONTOLOGIE SOCIALE

pluralages

FALL 2012 - Vol. 3, No. 1

living environments

Centre de recherche et d'expertise
en gérontologie sociale

Centre de santé et de services sociaux
Cavendish
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COVER

Isabelle Van Pevenage

REVISION AND TRANSLATION

Maude Beausoleil, Brita Brown, Annie Dulong, Céline Flahault, Dana Kobernick, Vanessa Nicolai, Marie-Chantal Plante and Daniela Sinai.

DESIGN AND PRODUCTION

Annie Blanchette

CONTACT

CREGÉS
5800, boulevard Cavendish, 6th floor
Côte St-Luc, Québec, H4W 2T5
phone : 514 484-7878, ext. 1463
e-mail : creges.cvd@ssss.gouv.qc.ca

Pluralages is published by the Centre de recherche et d'expertise en gérontologie sociale (CREGÉS) of the CSSS Cavendish-Centre affilié universitaire (CAU). This magazine is designed to inform the public and raise awareness of social issues surrounding aging by, among other things, presenting the research initiatives and expertise being developed by members of the CREGÉS. Pluralages also aims to promote and foster ties between the research, education, practice and citizen action - for and by seniors - communities. Issues related to aging are presented through the lens of social gerontology, touching on such themes as diversity in aging, social and citizen recognition of the elderly, experiences with social exclusions and solidarities, political concerns, State directives and public policy targeting the aging population and its needs.

Pluralages is published in French and English, in print and electronic versions. Please feel free to contact us for a paper copy in your preferred language.

ISSN 1920 - 7158 © **CREGÉS** - Centre de recherche et d'expertise en gérontologie sociale

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EDITORIAL

GROUNDED PRACTICES

APPLIED RESEARCH

STUDENT'S FORUM

CITIZEN'S FORUM

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People and Places

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Living environments are more than just physical locations; equally important are the people who live and work in them, and how they relate to one another.

The term "living environment" refers to a multitude of locations, ranging from a room in a residential and long-term care centre (CHSLD) to a neighbourhood or even a region. It is a flexible term that can be measured on a variety of scales. In a CHSLD, a person's living environment consists of his or her room and the common area where activities are held or meals are served. In rural areas, seniors' living environment can extend from their farm to the closest urban centre where they regularly access goods and services. For seniors with a very ill spouse at a CHSLD, the living environment comprises the family home and surrounding area as well as the CHSLD, which they frequently visit. In this issue of Pluralages, we will not attempt to provide exhaustive coverage of this broad and multi-faceted topic. Rather, we offer a basic overview of private and public living spaces available to seniors.

Living environments are more than just physical locations; equally important are the people who live and work in them, and how they relate to one another. Whatever their makeup, living environments clearly have both positive qualities and shortcomings. In any environment, there will always be advantages and drawbacks.

In the following pages, we have decided to focus on the positive rather than the negative aspects of various environments. We also point to possible solutions in order to counter the often negative stereotypes associated with aging and those active in the field (staff, students, etc.). Without minimizing the difficulties, obstacles and injustices experienced by seniors, we especially wanted to highlight initiatives aimed at improving the environments in which they live.

Happy reading!
The editorial board

Working in long-term care facilities:

Perspectives of staff at the CSSS Cavendish residential centres[1]

Geneviève Ouellette *BA*
Social Worker and Research assistant
CSSS – CAU Cavendish
genevieve.ouellette.cvd@ssss.gouv.qc.ca

To offer a different perspective on life in long-term care facilities, our editorial team decided to interview those who work directly with clients in what is sometimes an undervalued and misunderstood profession. Although the media often cast long-term caregivers in a negative light, these workers are extraordinarily dedicated and fulfill a variety of needs.

Barbara Grodecka
Licensed Practical Nurse (LPN)
St-Andrew

Danut Tica
Evening nursing Coordinator
Father-Dowd

Lynn Guilbault
Nurse Assistant
to the Immediate Superior (AIS)
Henri-Bradet

Meridee Larrat
Beneficiary attendant (PAB)
St-Margaret

WORKING IN LONG-TERM CARE FACILITIES

The willingness to contribute to the well-being of individuals weakened by illness, the possibility of exchanging with clients, an interest in the aging process and its related cognitive impairments... these are just some of the reasons the staff members we interviewed chose to work in a long-term care facility. Their expertise in geriatric care allows personnel to adapt care to residents' mental health and level of autonomy. This work does not involve the mechanical repetition of tasks; caregivers must be able to adjust their actions according to the circumstances at hand. They must be keen observers, since no two residents are the same and all have different needs. Despite an unavoidably fast work pace, staff must maintain

a sense of humour, and remain calmand patient. These personal qualities play an important role in the analysis, decision-making and interventions that occur on a daily basis with residents, their families and visitors. The integrity and strength of the intervention team depends on the experience and expertise of its members. They must be both good communicators and listeners, since the job involves meeting with residents and their families, as well as responding to a multitude of requests from residents, families and colleagues.

Teamwork is essential in such shifting environments, particularly since team members are involved in the decision-making process.

One of the positive aspects of working in a long-term care facility is that workers have the opportunity to deal with the patient as a complete person, not just a collection of symptoms. This means they can be involved in a more detailed and personal manner than would be the case in medical care alone. What makes this work very rewarding is the variety of geriatric issues encountered, the importance of interventions, the possibility of taking initiative and a fair amount of flexibility.

Small, daily gestures reflect the dedication of long-term care personnel who often witness important milestones in residents' lives. One interviewee related the case of a woman who arrived from hospital malnourished, in a wheelchair, with her head bowed and unable to feed herself. Within just a couple of months, she had gained weight, could walk with some help, was standing upright and could eat on her own. Added together, these small victories give meaning to this work.

ORGANIZATIONAL CONTEXT OF CARE AND THE LIVING ENVIRONMENT APPROACH

In 2003, the Quebec government modified the care approach that had been in place since the reorganization of health services in the 1980s (shift toward ambulatory care, day surgery, tightening of eligibility criteria for long-term care facilities, etc.). The government chose to adopt a new approach promoting the relationship between those being cared for and their relatives. This new approach has been implemented in a context of changes within residential centres, bed closures and budget cuts.

The assignment of cases in long-term care is managed via a centralized system that forces residential centres to accommodate all clients. Today, clients come mainly from hospitals rather than from their homes, which entails a greater provision of acute and medical care than in the past. Geriatric clients with cognitive impairments (with or without wandering) and disruptive behaviours, as well as adult clients with multiple disabilities are on the rise.

Since 2009, there has been a progressive closing of chronic care beds in Montreal's general hospitals, forcing the CSSS network to offer PHPE[2] beds within their long-term residential facilities. Clients remain in these PHPE beds on a temporary basis while waiting to be redirected to a transitional residence and then transferred to a permanent residential centre. This new clientele has transformed the work of long-term care teams and is a source of anxiety for permanent residents who wonder whether their spots have now become temporary. It is difficult to build a close relationship in such a transitory context, where staff and residents are confronted by these types of policies. "Long-term care" loses its meaning in the face of a constant turnover of residents.

POSITIVE ASPECTS OF THE LIVING ENVIRONMENT APPROACH

The living environment approach emphasizes the relationship between the individual, the care team and the relatives. The staff members we interviewed said they apprecia-

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ted the new approach and are actively incorporating it into their daily work in the units. Quality of care (acute, regular or palliative) is paramount. Teamwork is essential in such shifting environments, particularly since team members are involved in the decision-making process. The group *"Agir"* has been pivotal in publicizing the living environment approach, which involves all members of the unit: nurses, auxiliary nurses, nurses' aides, physicians, kitchen personnel, recreational therapists and many others. The goal is to transform mechanical gestures of care into more personal ones.

The positive effects of this approach on residents' lives are real, as shown in the following examples, related during the interviews. The stability of the staff and teams creates a synergy among team members, which ensures a pleasant working environment. Clients benefit from seeing familiar faces. Care is taken in the matching of caregivers and clients as well as in the matching of residents in the dining room, where varied meal options are provided according to clients' needs. Whenever possible, bathing times are planned according to residents' usual routines and the same goes for mealtimes and bed times. The teams have found a way to reduce restraining measures and come up with alternative solutions. Currently, staff members are trying to reduce the use of medication, since physicians have agreed to work with them on this matter. Caregivers encourage residents to be autonomous by offering assistance instead of doing actions for them (e.g., tooth brushing). The result is greater satisfaction on the part of both residents and staff, with the latter feeling they have contributed to residents' well-being. In practical terms, this approach has allowed for the development of stimulating activities for residents, such as bread-baking and tea in the solarium. In addition, staff members are planning to organize a short stay outside the residence for clients with dementia and a severe loss of autonomy.

The living environment approach is geared toward the well-being of residents. Families notice that staff members work with clients' best interests in mind, and that they are open to communication. Even though its implementation poses new challenges in terms of routines and staff management, this approach allows a degree of freedom of action in an otherwise strict environment. Some administrative procedures still need to be eased in order to create the space and time necessary to provide care with a human touch.

According to the staff members interviewed, research should focus on how to reduce the use of medication; the influence of the physical environment on residents; and the impact of training on the quality of services provided.

PROPOSALS FOR IMPROVEMENT

The growing number of clients at long-term care facilities makes it challenging to implement the

living environment approach. We need to find innovative ways to combine the medical and humane aspects of care.

Residents' declining health and loss of mobility limit their movement within the unit. We will therefore need to rethink recreational activities in order to tailor them to each resident. Unfortunately, staff shortages can hinder this endeavour. We nonetheless have to find ways to offer pleasant moments to clients with a loss of autonomy, and to create a living environment that caters to their interests.

In long-term care, the needs are endless—as are the obstacles, which can nonetheless become stimulating challenges if we remain focused on patients' well-being. The physical environment must be designed to meet their needs and ensure their safety. In an ideal world, there would be sufficient staff to offer all residents the care they need at the appropriate time, and create an optimal living environment.

1. *These interviews were conducted in July 2012 with four staff members at the CSSS Cavendish. The Henri-Bradet, Father-Dowd, St-Andrew and St-Margaret residential centres offer between 70 and 134 beds.*
2. *Better known as Program 68, the PHPE (Programme d'hébergement pour évaluation) involves assessing transition-care patients to determine the type of placement required.*

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Aging Seniors and their Environment: A must for Health Professionals to Consider

Isabelle Daneau *MSc*

Occupational Therapist – CLSC René-Cassin
CSSS – CAU Cavendish
isabelle.daneau.cvd@ssss.gouv.qc.ca

AGING AND LOSS OF AUTONOMY: A CHALLENGING ISSUE FOR SOCIETY

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The loss of autonomy that is linked to aging is well known in today's society due, in large part, to the rise in the aging population and to all of the challenges that this poses to our health-care system. Loss of autonomy in the elderly is linked to various causes that we mostly attribute to normal stages of aging, including illnesses that can affect them and lead to physical and cognitive impairments. In this context, the older person's environment becomes an unavoidable factor to consider if we are intent on promoting his/her independence by allowing him/her to remain at home as long as possible.

In occupational therapy terms, loss of autonomy translates into a decrease in activity level. Activity level is defined as "the capacity of a person to choose, to organise and to perform significant activities which give them satisfaction. These activities, as defined by culture and age group, allow clients to take care of themselves, to enjoy themselves, and to contribute to the social and economic growth of the community"[1]. The Canadian Occupational Performance Measure (COPM),

of which this definition is a part of, explains that occupational performance is varying, as it derives from the constantly evolving interactions between the person's capabilities, the activities that he or she has to or wants to perform and the environments within which he or she resides. These elements all influence one another so that these activities may or may not be accomplished. Therefore, by modifying even just one of these elements, we can influence the occupational performance of an individual.

The environment is a very important factor in the outcome of occupational performance as it plays two roles, that of impeding the accomplishment of activities, or that of allowing and promoting their accomplishment. When there is a large discrepancy between the person's capabilities and his or her environment, the attainment of occupational goals is most often compromised[1]. However, in order to reestablish a balance, the environment is an easier element to modify than the severity of the disabilities, or the person's occupational needs. In a social context where the emphasis is on caring for the elderly to enable them to stay at home, an understanding of the impact of the environment on that person's occupational performance is fundamental to the development of strategies which will lead you towards that goal.

Unfortunately, for some individuals, changing their environment may not be enough to offset their incapacities. In such cases, a transition towards a substitute living environment, such as a long-term care facility (CHSLD), an intermediary resource (IR) or a family-based resource (FBR) is necessary to maintain that person's occupational performance and safety[2]. All of these environments, whether they are institutional or not, differ greatly from those that the person has been used to and often craves. That is why it is of the utmost importance that these environments try to recreate, whenever possible, a natural living environment that fulfills the needs, allows the routines, and embraces the values and tastes of the individual that has been welcomed, as well as his or her family[2]. Since every individual is unique and different, these living environments must adapt and be open to constant change in order to adjust to the evolving needs and personal growth of each individual.

DIMENSIONS OF OCCUPATIONAL PERFORMANCE

Most models of occupational performance in occupational therapy include the environment as one of their key elements[3]. The COPM divides this element into four categories: physical, social, institutional, and cultural. Each of these categories then includes different dimensions which influence the occupational performance and can be modified to varying degrees[1].

The physical environment is made up of all that is material. This includes both the natural environment and the elements created by people. In cases of physical or even cognitive incapacity, the physical environments, within which the individual evolves, often present obstacles or shortcomings[1,4,5]. One striking example is that of an older person with mobility issues who can no longer use the stairs to leave his or her house. The community itself can also present numerous physical barriers that limit the access of persons with incapacities. In an ideal world, our life settings would be built according to the principle of universal accessibility, thereby allowing every person, regardless of age and capacity, to access it. Unfortunately, that is not the norm in our world today[4,5]. In that regard, one of the measures that can increase an individual's occupational performance is physically adapting homes and public settings. In addition, there are also technical aids which are essential to helping an individual adapt in and that he or she can rely on to facilitate activities or make them safer. Some concrete examples of such

In an ideal world, our life settings would be built according to the principle of universal accessibility, thereby allowing every person, regardless of age and capacity, to access it.

aids include using a support bar to safely get in and out of the shower, a wheelchair to get around, or a timer as a reminder to take one's medications.

The social environment is comprised of all the people that revolve around the individual. It includes the relationships that he or she maintains with family and friends or with the professionals that he or she comes into contact with. The scope and quality of this network can greatly vary. For some, this network is quite limited, whereas for others, it can be very extensive. As with every other component of the environment, the social dimension can either hinder or facilitate occupational performance. For many seniors living at home, their entourage and health professionals play a pivotal role in allowing them to remain at home by way of the services they offer and the activities that they participate in with them. A good example of this is that of an adult child running errands or taking his or her mother to her appointments. On the other hand, a poor social network, or one fraught with conflict-ridden relationships can negatively affect a person's occupational performance, and even hinder it.

The institutional environment is made up of all that relates to politics, laws, social programs, executive committees and management[1]. Although these aspects seem far removed from the daily occupational performance of an individual, this dimension is of great importance in the achievement of societal goals, whether they involve keeping an elderly person living at home for as long as possible or ensuring quality care in long-term care facilities. For example, staff shortages in long-term care facilities can negatively impact seniors' quality of life, as we have often seen in recent headlines.

Lastly, a senior's cultural environment can also affect their occupational performance. This dimension is made up of all the "ethnic, racial, ritual, and routine aspects of a particular group's belief system[1]." A good example of how the cultural dimension can increase occupational performance is the importance of family values within a community; these can encourage children to care for their elderly parents, even to the point of bringing them to live in their home. Different cultural elements, along with each individual's intrinsic belief system, will either facilitate or hinder adapting to an environment, or the transition between one environment and another.

The goal of helping seniors, who are experiencing a loss of autonomy, to remain in their homes can be reached insofar as that individual's environment can be adapted to increase, improve, or maintain occupational performance. However, there may come a time when the imbalance is so great that it requires the transition from a natural living environment to a substitute living environment. Regardless of where a senior is living, the main goal of occupational interventions should be to maximize that person's occupational performance through the utilization of all their capacities. In that regard, all interventions aimed at the environment, whether on a physical, social, institutional or cultural level, are key elements to reaching that goal.

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Choosing a Living Environment for a Relative with Dementia : Developing a Decision Aid for Caregivers

Mélanie Couture *PhD*
Researcher, CREGÉS
CSSS – CAU Cavendish
melanie.couture.cvd@ssss.gouv.qc.ca

Francine Ducharme *PhD*
Professor, Faculty of Nursing Sciences
Université de Montréal
Researcher, CRIUGM
francine.ducharme@umontreal.ca

The tool was developed as part of my post-doctoral work under the supervision of Francine Ducharme. The idea of developing a decision aid came from the results of several studies which were conducted with caregivers of people with dementia. These studies demonstrated the need to better support caregivers when making decisions regarding the living environment of their family member.

A DIFFICULT CHOICE

In the past ten years, the Quebec health care system has concentrated its efforts in promoting home support to allow seniors to remain in their homes as long as possible. As a result, we have two policies well in place that illustrate the government's efforts in this realm, the home support policy "Chez soi : le premier choix[1]", presented in 2003 by the Ministry of Health and Social Services, and the new policy, "Vieillir et vivre ensemble, chez soi, dans sa communauté au Québec[2]", presented in May 2012 and sponsored by the Ministry of Families and Seniors in collaboration with the Ministry of Health and Social Services. Nevertheless, relocation must be considered for seniors whose families and formal homecare services no longer fulfil their needs.

With respect to people with dementia, it is often the relatives, children in particular, who undertake the relocation process[3]. The decision-making process involved in the placement of a relative is considered by caregivers as "difficult" and "heart-breaking[4]." In addition, planning for such a change in living environment is often carried out quickly and in situations of family crisis, which makes the decision process that much more painful[5]. Often, families will avoid the question of placement altogether, which doesn't allow for reflection in planning before the need becomes immediate.

Caregivers report that health professionals can support them in this decision-making process by primarily helping them to :

- evaluate the need for change in the living environment of the relative;
- navigate the health care system;
- take care of the family dynamic[6].

However, some caregivers who had to resolve themselves to placing a relative, say that the decision-making process is often based solely on the practitioner's expertise and that they feel that caregivers are not adequately informed[5]. A better understanding of caregivers' needs and perceptions would allow for proactive intervention and more informed decision-making with respect to choosing an appropriate living environment for their older relative.

This guide offers all persons involved an opportunity to express their view of the situation and gives power back to the caregiver who must make an important decision regarding a relative who is no longer able to make decisions on his or her own.

AN AID TO PROMOTE INFORMED DECISION-MAKING

In Quebec, case managers such as social workers, nurses, and occupational therapists manage access, coordination and follow-up of services in many Quebec Health and Social Service Centres (CSSS). At the time of institutionalization, these health professionals become the intermediaries in the complex relationship between the senior, the family and the health care system[3]. Once a formal request for placement is received, the case manager fills out a standardized form with the family. It is worth noting however, that prior to the official formulation of a placement request, there is no existing process or protocol in a CSSS that helps caregivers in their reflections regarding choosing a living environment for their relative with dementia.

Guides to help the decision-making process are clinical aids that aim to support people in structuring their decision process. This type of aid is particularly useful in facilitating decisions based on values and individual preferences, while encouraging dialogue between clients and health professionals[7]. With this approach, case managers can discuss with the caregivers at an earlier stage the possibility of changing the living environment of the person with dementia. A partnership is then established between the caregivers and the case managers which enables each person to express his or her view of the situation and allows the caregiver to feel empowered in making a decision regarding a living environment best suited to his or her relative. Given the cognitive disabilities of seniors with dementia, the partnership develops between the caregiver and the health professionals when the decision is made.

It is in this perspective that a guide to assist in decision-making was conceived in order to facilitate dialogue with respect to the eventual change of living environment of a person with dementia[8]. This guide addresses all changes of living environments, such as moving to a long-term care facility, intermediate resource, specialized unit, private residence, or even to another caregiver.

In order to provide an aid that is adapted to a caregiver's situation, the preliminary version of this guide was based on a systematic analysis of qualitative research addressing the decision-making process of caregivers as it relates to placement of a relative with dementia. This analysis allowed for the identification of:

- the primary concerns of caregivers throughout the decision-making proces;
- the contextual factors that inhibit or facilitate the decision-making process.

Analysis of what has been written on this topic demonstrates that the primary concerns of caregivers throughout the decision-making process are the evaluation of the current living environment and the evaluation of the living environments being considered. The caregiver intuitively evaluates the ability or inability of the current living environment to fulfil the needs of the senior. More precisely, he or she considers the cognitive and

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physical state of his or her relative with dementia, safety issues, his or her own physical and psychological capacities as well as the formal and informal help available. Caregivers also evaluate whether the new living environment under consideration can fulfill the senior's needs. With respect to the choice of a new home for their relative, caregivers primarily evaluate the quality of care, the geographical proximity and the cost. The most important contextual factor in making the decision is the acceptability of such a change in living environment for the different people involved. The caregiver must combine his or her own perception of the situation with that of the other people involved (the person with dementia, friends, family and the health professionals) in order to choose the best living environment for his or her relative with dementia.

Based on the results of the analysis of the existing literature on this topic, the guide for the decision aid was conceived with the goal of enabling case managers, using open-ended questions, to explore the perceptions of caregivers in relation to:

- their evaluation of the current living environment and the living environments being considered;
- their willingness, as well as that of the people in their entourage, to accept the change in living environment of their relative;
- their need for information and support with respect to decision-making.

The use of open-ended questions (rather than multiple choice questions) gives caregivers a greater sense of control during the meeting, which helps them to express the important aspects of their personal experience more easily. Case managers can then determine, with the help of the caregiver, the most critical needs. This guide was conceived for use in the context of a meeting lasting approximately one hour, between the case manager and the caregiver. Additional meetings can be offered if necessary.

THE NEXT STEPS

The preliminary version of the decision-aid guide was validated with case managers and caregivers who already participated in the decision-making process and the aid was then further refined. In the fall of 2012, CSSS de la Montagne and CSSS Cavendish will be testing the validated and improved version of the decision-aid guide with 10 pairs of caregivers and case managers wanting to address in greater depth the decision-making process for choosing a living environment for a person with dementia. Given that for some caregivers the choice of a living environment for their relative is a sensitive subject, the caregivers recruited for this pilot study will have already expressed their desire to discuss a change in living environment for their relative.

Following the pilot study, French and English versions of the aid will be available for health professionals wanting to deepen this reflection process with caregivers. The decision-aid guide was specifically developed to help caregivers of people with dementia. Other studies will be necessary to adapt this guide to other contexts and other clienteles.

The decision-making process linked to the change in living environment of an older relative with dementia is fraught with uncertainty for caregivers and it is befitting to support them during this sensitive time. This guide offers all persons involved an opportunity to express their view of the situation and gives power back to the caregiver who must make an important decision regarding a relative who is no longer able to make decisions on his or her own. Health professionals can then use the information gathered regarding the needs expressed by caregivers to develop new interventions that will better support them during this critical decision-making process.

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The influence of personal and environmental factors on the walking habits of Montreal seniors

Sophie Laforest *PhD*

Scientific Director and Researcher, CREGÉS
Professor, Department of Kinesiology
Université de Montréal
sophie.laforest@umontreal.ca

Research collaborators: *Lucie Richard, PhD, Université de Montréal, Céline Gosselin, MSc, Direction de santé publique de Montréal, Lise Gauvin, PhD, Université de Montréal, Kareen Nour, PhD, Agence de la santé et des services sociaux de la Montérégie, Josiane Desroches MSc, Université de Sherbrooke.*

Environmental factors influence the walking habits of seniors in urban areas. This is the conclusion of a 2005 study that aimed to show the connections between the built environment (buildings, parks, roads, public transit network, etc.) and the walking habits of urban-dwelling older adults, taking personal factors into account as well. The proximity of services doubles the chances that seniors will walk on a daily basis; a pleasant, pedestrian-friendly environment increases this likelihood fourfold; and a safe environment increases it threefold. Aesthetic appeal and a variety of destinations also double their chances of walking.

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Over the course of the study, 282 elderly individuals were recruited via community organizations in Montreal. An interviewer had the participants complete a questionnaire in order to record their walking habits, socio-demographic variables, health-related variables (age, gender, education, housing, health status, mental health), and neighbourhood characteristics (perceived proximity of services, variety of destinations, accessibility of resources, walkability, walking facilities, aesthetics, access to a metro station or bus stop within a five-minute walk, and safety). Various analyses were carried out to better understand the wide range of responses from participants. To explore the relationship between environmental variables and walking habits, regression analyses were conducted. The goal was to identify the variables most strongly associated with walking, after controlling for personal variables likely to bias or modify the results. An acceptable margin of error for these associations ($p<.05$) was estimated to be 5 percent.

As part of the study, we adopted a subjective measure of perceived environmental factors, combined with a self-reported walking measure (weekly frequency). We believe that the perception people have of their neighbourhood environment is a reliable indicator.

A variety of neighbourhood factors were studied:

- distance of services;
- variety of destinations;
- perceived accessibility of eight key resources;
- walkability;
- walking facilities;
- aesthetic appeal of the environment;
- access to a metro station or bus stop within a five-minute walk;
- feeling of safety.

It is important to note that when these variables were factored into a model including personal characteristics, the latter were never associated with walking. In other words, only environmental variables turned out to be motivating factors.

THE CONNECTION BETWEEN THE ENVIRONMENT AND WALKING

Studies conducted among the general population have demonstrated a positive association between regular walking and the presence of environmental factors promoting accessibility[2]. For examples, Saelens and his colleagues have noted that groups in areas where there is high residential density and street connectivity, or where there is mixed land use, walk or cycle more for practical purposes than groups in low-density, poorly connected areas with less diverse land use[3].

Although the results of these studies are interesting, very few of them specifically refer to the elderly population. Yet we know that the influence of the built environment on physical activity varies according to age groups[4] and that the elderly spend more time in their neighbourhood than average-age adults. In addition, as people get older, they lose access to private modes of transportation and have to use other modes such as public transit and walking[5]. That is why it is essential to understand the relationship between the characteristics of the built environment and walking habits.

PEDESTRIAN-FRIENDLY NEIGHBOURHOODS

Some neighbourhoods have pedestrian potential (connectivity, mixed land use, shady sidewalks, etc.), a safe environment (safety lanes between pedestrians and motorized vehicles, safe crosswalks, well-lit streets, etc.), aesthetics (cleanliness, green spaces, etc.) or a variety of destinations. The presence of these factors facilitates physical activity and their absence poses a barrier[6]. Previous studies on the impact of certain neighbourhood factors on walking are unanimous on some points. For example, all recognize the connection between a neighbourhood's pedestrian potential and the population's engagement in physical activity[7]. The same is true of the following factors: variety of destinations, safety and access to sports and recreation facilities[4]. However, opinions differ regarding access to pedestrian walkways. The limited number of publications on each factor, the diverse range of municipalities in which the studies were conducted, and the disparities among the studied population make it difficult to generalize the results; more extensive research is required.

Statistics Canada reports that in 2005, the prevalence of sedentary behaviour (which increases with age) was 56 % among men and 64 % among women aged 64 and over.

SENIORS AND WALKING

Countering physical inactivity among seniors is a major challenge. Statistics Canada reports that in 2005, the prevalence of sedentary behaviour (which increases with age) was 56 % among men and 64 % among women aged 64 and over[1]. This, despite the fact that a sedentary lifestyle increases risk factors related to cardiovascular disease. In fact, walking is key to seniors' health, helping to maintain or increase their autonomy and extend their life expectancy[8].

CONCLUSION AND AVENUES FOR REFLECTION

Among those interviewed for this study, 40 % did not walk on a daily basis. Walking plays a vital role in the health status and well-being of the elderly[9]. It is therefore essential that we develop strategies

to promote walking among seniors, especially since they appreciate this accessible activity. The presence of many of the factors mentioned above is also necessary to help urban-dwelling seniors develop good walking habits. We therefore urge community planners, health-care providers and seniors to draw inspiration from our study and others[3,10,11]. We also hope that municipalities and the various government bodies likely to finance urban planning projects take note of these observations.

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Aging Issues

Through the Lens of Urban Planning and Geography

Anne-Marie Séguin *PhD*

Professor and Researcher
Institut national de la recherche scientifique (INRS), Centre Urbanisation Culture Société
Member: Laboratoire d'analyse des politiques sociales et des territoires (LAPoSTe)
anne-marie.seguin@ucs.inrs.ca

Paula Negron-Poblete *PhD*

Professor and Researcher
Institut d'urbanisme
Université de Montréal
Member: Observatoire de la mobilité durable and LAPoSTe
p.negron-poblete@umontreal.ca

Philippe Apparicio *PhD*

Professor and Researcher
INRS, Centre Urbanisation Culture Société
Member: LAPoSTe
philippe.apparicio@ucs.inrs.ca

A number of disciplines in the health and social sciences have turned their attention towards the aging of the population. Family medicine and nursing in the former, social work, sociology and psychology in the latter, along with geriatrics, work towards both a better understanding of the issues related to aging and more efficient ways to help the population.

But how can disciplines that look at space, planning and land use make a relevant contribution to our knowledge in this field?

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It is important to examine land use from different angles when looking at aging, firstly because Quebec's population will be aging rapidly over the next three decades. This change will affect all regions but in varying degrees and at different rates. The second reason for this interest in land use lies in the Quebec government's position on aging, recently laid out in the policy *"Vieillir et vivre ensemble, chez soi, dans sa communauté, au Québec"* [Aging and Living Together, at Home, in One's Community], launched in May 2012.

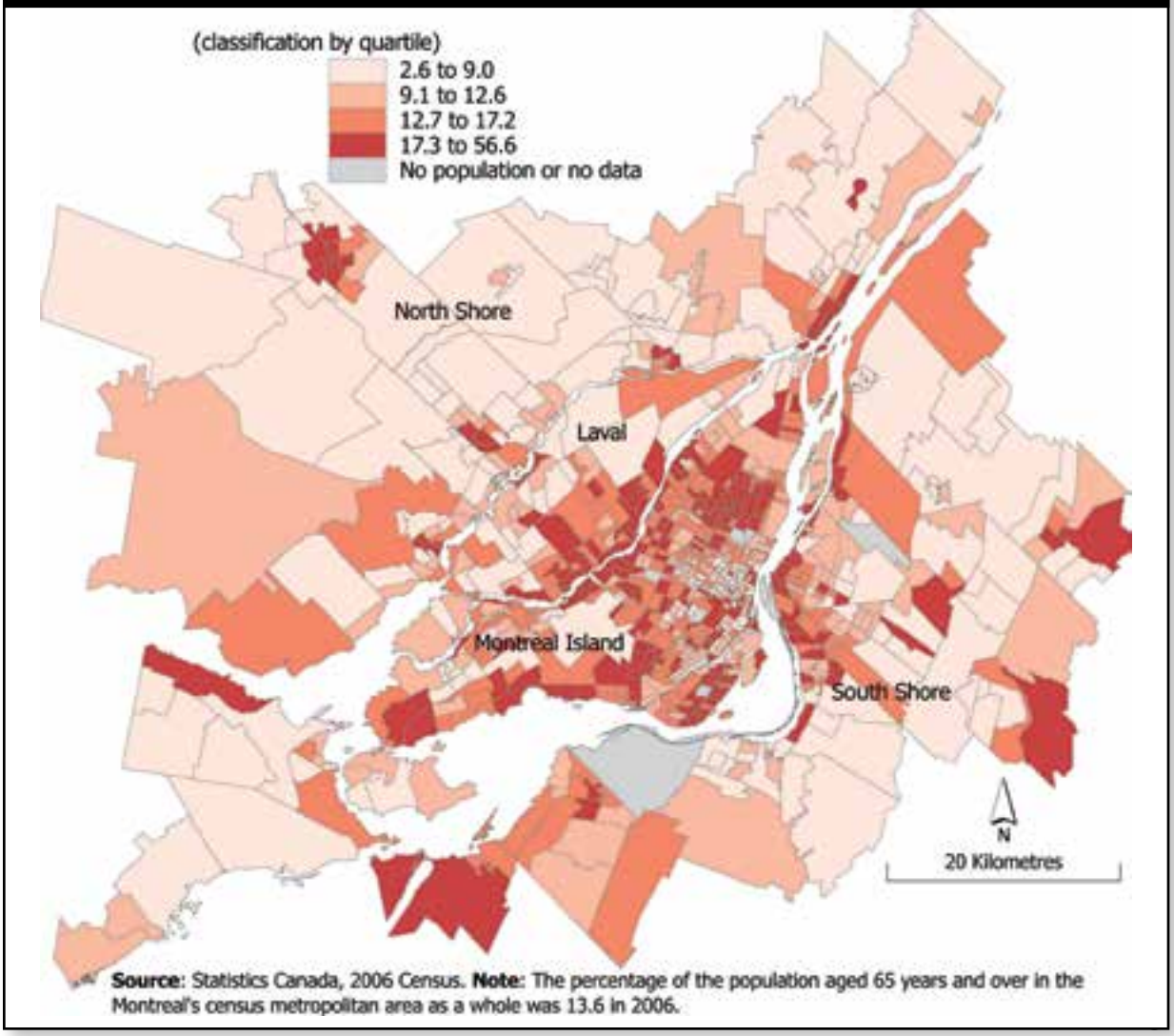
A cornerstone of this policy is to keep seniors in their community and at home as long as possible. To avoid a possible negative impact of this policy direction on seniors, we must ensure that current and future residential settings can accommodate their needs[1], even when their health status makes them less mobile.

We will briefly present two case studies to illustrate how geography and urban planning can help guide decision-makers to adapt land use to the needs of an aging population. The first study looks at the distribution of the elderly population within the Greater Montreal Area, which is home to close to 48% of Quebec's seniors, while the second examines the accessibility of businesses and services in parts of a Montreal suburb.

THE CHANGING GEOGRAPHY OF MONTREAL'S ELDERLY POPULATION

The first study[2] asks the following question: are seniors spread sufficiently uniformly across the Montreal area or, on the contrary, are they concentrated in certain neighbourhoods? A better understanding of the geographic distribution

MAP 1 - PERCENTAGE OF THE POPULATION AGED 65 YEARS AND OVER BY CENSUS TRACT



Source: Statistics Canada, 2006 Census. **Note**: The percentage of the population aged 65 years and over in the Montreal's census metropolitan area as a whole was 13.6 in 2006.

of people aged 65 and over, as well as changes that have occurred over the past 25 years, can facilitate the planning of optimal locations for public services targeting this population (medical clinics, senior centres, specialized recreational equipment, etc.), and thus better meet its needs.

One of the most interesting results of the study was to show that this distribution evolves over time, which poses a challenge in terms of planning and services. The study revealed that, in the 1980s, seniors were mainly concentrated in the neighbourhoods located in the core of the former City of Montreal (as defined prior to the 2002 mergers), as well as in cities such as Outremont, Côte Saint-Luc and Verdun. They were present in much smaller numbers outside the centre of the island of Montreal, with a few exceptions, such as in Sainte-Anne-de-Bellevue. This model of concentration of seniors in central neighbourhoods has also frequently been observed in other cities in the United States and Canada. Why is this so? A number of factors have been suggested: seniors tend to stay in areas where they have lived before the age of 65; the poverty frequently observed among seniors in the early 1980s confines them to poor neighbourhoods with cheap, small apartments; in other words, in the old neighbourhoods surrounding the downtown area.

In 2006, a rather different distribution model was observed (see Map 1). A number of old neighbourhoods in central Montreal, such as the Plateau Mont-Royal, had attracted younger residents, and seniors were found to be proportionally much less present. They are now concentrated in more recent Montreal neighbourhoods such as parts of Ahuntsic or Mercier or in suburbs close to Montreal (the southern part of Laval and some parts of Longueuil), while the more distant suburbs still have low percentages of senior residents. How to explain these changes in the spatial distribution of the elderly population over a 25-year period (1981 to 2006)? The tendency for seniors to "stay put" is still a decisive factor: a number of adults who have lived in inner suburbs stay there past the age of 65, a situation made easier by an overall improvement to the seniors' incomes, although poverty is still present among this group, particularly with women who live alone. Since their retirement income is higher than that of previous generations of retirees, seniors can continue to stay in their homes if they choose so. In addition, there is a wider range of available housing in the municipalities of inner suburbs: there are a lot more rental and condominium units, sometimes even in buildings reserved for seniors. This means that when, for a variety of reasons, seniors decide to leave their single-family homes, they can find housing in the same area. Others can move into these neighbourhoods as well. How far will the aging population spread within the Montreal area? Will it reach the municipalities of outer suburbs such as Vaudreuil or Blainville? We cannot provide a definitive answer to this question at this point.

These changes in the spatial distribution of seniors evince the need to plan public and private facilities in order to serve populations of other age groups in the future. Research has shown that there is a cycle of change in many neighbourhoods and cities in the Montreal area.

These changes in the spatial distribution of seniors evince the need to plan public and private facilities in order to serve populations of other age groups in the future. Research has shown that there is a cycle of change in many neighbourhoods and cities in the Montreal area. Thus, young families settling in a new neighbourhood will, in time, become families with grown-up children. When these children leave the family home, their aging parents might end up leaving the neighbourhood. A new cycle is started with the arrival of young

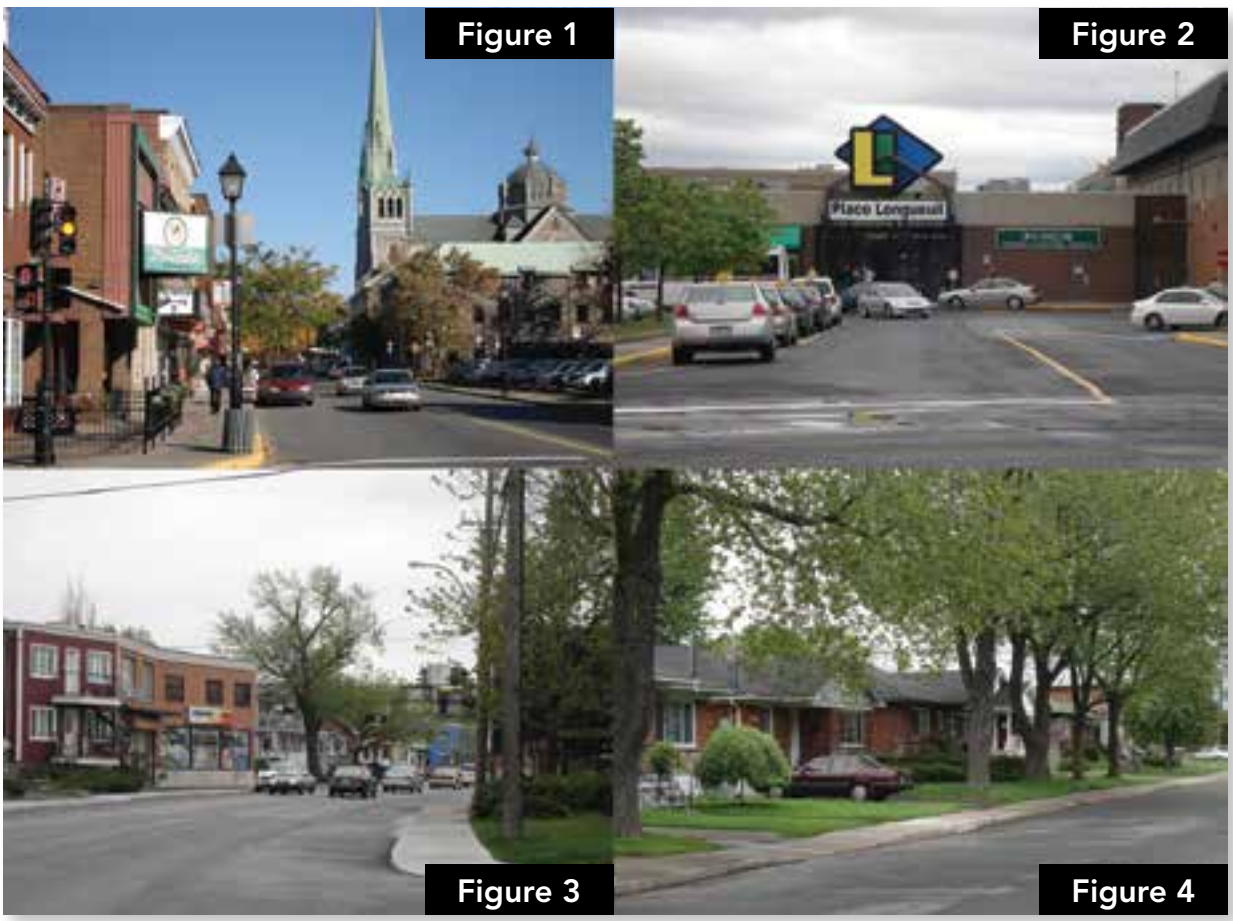
families who take their place. Of course, not all the residents in a given neighbourhood follow this pattern, but many do or at least have done so in the past.

PEDESTRIAN ACCESSIBILITY OF BUSINESSES AND SERVICES IN A MUNICIPALITY IN AN INNER SUBURB OF MONTREAL

Our research team also observed aging in inner suburbs, which are residential areas planned for young families. We wondered whether the residential setting met the needs of seniors, particularly those without a car. A preliminary exploratory study was conducted in the borough of Vieux-Longueuil.

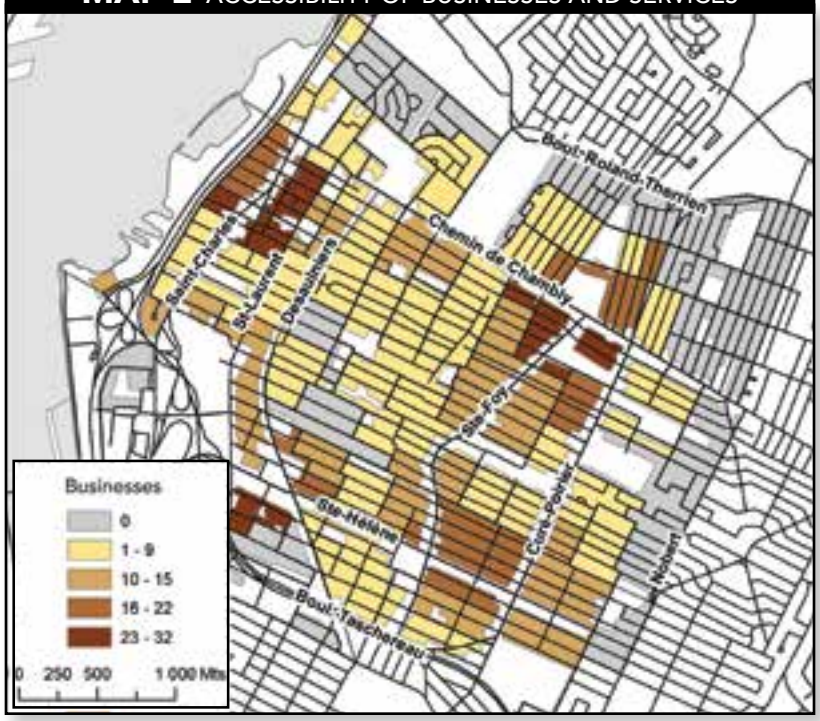
This second study[3] aimed to assess the pedestrian accessibility of common businesses and services in the borough of Vieux-Longueuil, one of the oldest suburbs in the Montreal area. The results showed that walkability was very uneven in the study area, particularly if the range of businesses and services was factored into the accessibility analysis. The most pedestrian-friendly sectors were those near major arteries, on the periphery of the study area. In 2006, people aged 65 and over were mainly concentrated near Saint-Charles Street, in the northwest periphery—an area with many businesses and services. However, the tendency of aging residents to stay where they are might lead to major concentrations of seniors in the central part of the suburb since the study showed that the pedestrian accessibility of businesses and services was lowest in this area, and that food offerings were the least diverse, often limited to convenience stores.

The study also revealed that the pedestrian accessibility of businesses and services in different sectors



was closely related to the period in which they were developed (Map 2). Sectors located along Saint-Charles Street, the main street of the former village, are easily accessible by foot (between 23 and 32 businesses within a 500-metre radius). Blocks of small streets and narrow lots have promoted high residential density mixed with commercial land use. In addition, the layout of the street (wide sidewalks, landscaping, benches, etc.) makes Saint-Charles Street very conducive to walking (Figure 1).

MAP 2 - ACCESSIBILITY OF BUSINESSES AND SERVICES



The pedestrian accessibility of sectors near the intersection of Chemin de Chambly and Boulevard Sainte-Foy can be qualified as average (between 16 and 22 businesses within a 500-metres radius). This mixed-use area includes street-level businesses and one of Quebec's first suburban shopping centres (Place Jacques-Cartier). The sectors near other major arteries (Saint-Laurent and Curé-Poirier, for example) are also very walkable. However, these sectors were developed after the Second World War, in a context of more widespread automobile use. The businesses often have vast parking lots in front (e.g., Place Longueuil, Figure 2), which pedestrians are obliged to cross in order to reach the store, making pedestrian access quite unsafe. In addition, high traffic volumes make it difficult to cross these roads, particularly for seniors with reduced mobility.

In the central part of the study area, there are mainly single-family homes and duplex houses. This low residential density makes it difficult to develop commercial activities. Some businesses and services have been established near intersections and along the busiest roads (e.g., Boulevard Ste-Foy, Figure 3) but food offerings are still limited, with little variety since most of the retailers are complementary (convenience stores, snack bars). There is also a network of poorly connected streets, which greatly reduces pedestrian accessibility. This is particularly true of the sectors making up the central portion of the area, where there are fewer than ten business and services within 500 metres.

The study therefore showed that far from being homogenous, Montreal's oldest suburb has highly varied levels of pedestrian accessibility. more adapted to the needs and mobility of seniors while other, more recent layouts, planned to facilitate automobile access, make walking very difficult or even dangerous for this group. On the other hand, some sectors with few businesses are very pleasant for recreational walking, because of their abundant vegetation and low traffic volumes (Figure 4).

Given the tendency for the aging population to "stay put," more and more seniors want to spend their golden years in the low-density areas where they have spent most of their adult lives but where pedestrian accessibility has not been factored into urban planning. It is therefore important that we begin to modify these areas immediately. Urban planning practices need

to be reviewed (subdivision by-laws, building regulations, zoning plans, etc.) in order to increase the density of these areas and allow for more mixed-use development (residential, commercial, institutional). Modifications must also be made to public spaces along roads with heavy traffic, where most businesses are located, in order to make them safer for seniors. Given the lower density in these areas, which reduces pedestrian accessibility, we also need to think of new ways to access public transit (e.g., shuttles), taking into account the needs and mobility of seniors.

Measures to increase the accessibility of businesses and services can also guide decisions on optimal locations for senior housing developments. Doing so will insure that residents keep the option of walking, thus maintaining their autonomy and staying fit.

GIVING A VOICE TO SENIORS

In Quebec, there are still relatively few geography and urban planning researchers who focus on aging. Much work remains therefore to be done to identify the major shortcomings of residential settings and to understand the needs of seniors. Giving them a voice and recognizing their diversity will be an important step, since seniors are in the best position to identify their own needs, as well as the barriers and problems they encounter in their daily lives. Seniors should also be closely involved in the search for solutions. This is one of the challenges taken up by the VIES research team (Vieillissements, exclusions sociales et solidarités), which is seeking to involve seniors in its research and to focus some of this research on people's living environments.

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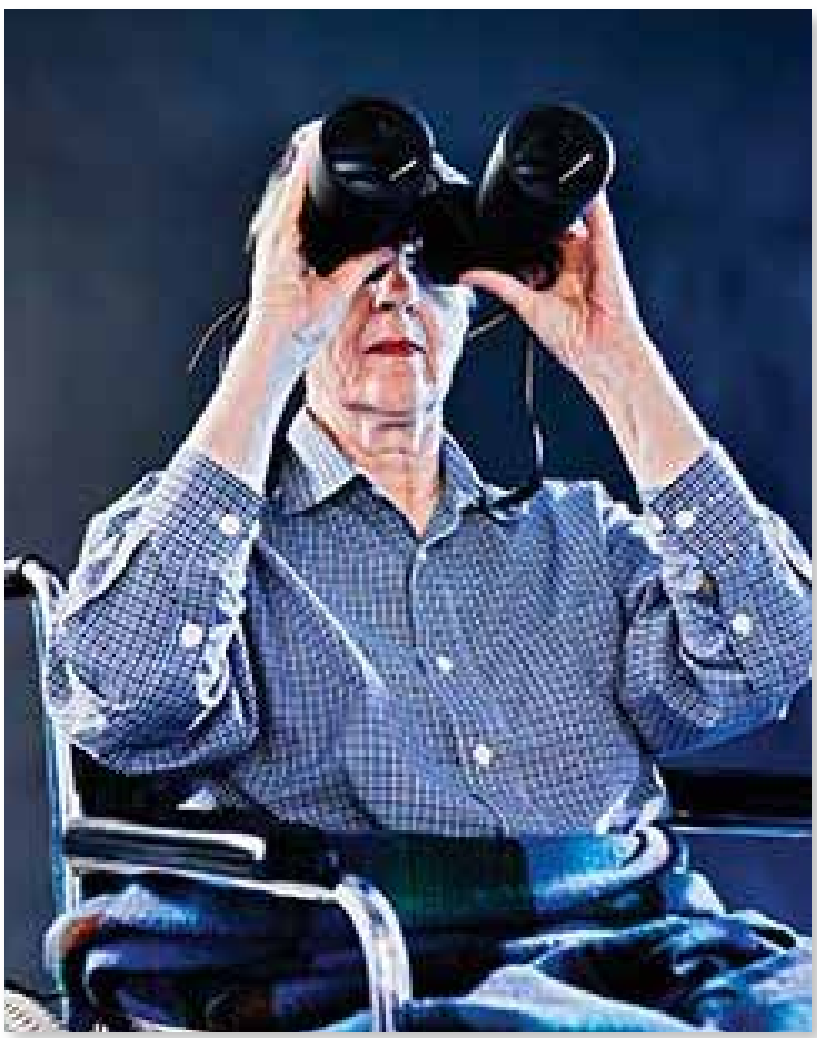

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For a Better Access to Fruits and Vegetables

Emily Bell
Master's candidate in Human Nutrition
McGill University
emily.bell2@mail.mcgill.ca

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Community nutrition initiatives can be an effective way to raise awareness about healthy eating and can significantly improve access to food. One of those programs is the Good Food Box (GFB), a food-buying club that provides community residents with affordable, healthy and fresh produce. The consumption of fruits and vegetables is important, as this food group provides a wide range of nutrients necessary for optimal health and helps to lower the risk of illness. Research shows that people who eat substantial amounts of fruits and vegetables have reduced risk of chronic diseases such as heart disease, stroke, type 2 diabetes, hypertension and some cancers[2,3].

Targeting this demographic is significant, since Côte Saint-Luc has a high proportion of elderly citizens, with 30.2% of the population aged 65 and older, and 7.1% aged 85 and older[4]. Furthermore, 42.3% of those aged 65 and older live alone, and 3,770 individuals in the community are widowed. This community-based GFB program thus aims to provide these residents with affordable and nutritious produce in order to ameliorate health status, and simultaneously promote local agriculture and community involvement.

Traditionally, the GFB has targeted low-income families and individuals; however, the Centre local de services communautaires (CLSC) René-Cassin has begun a 10-week long GFB pilot project in the City of Côte Saint-Luc aimed specifically at isolated elderly clients. The elderly often have inadequate nutrition due to aged-induced physiological, functional or social changes[5,6]. For example, those who are recently widowed or housebound, or who lack family support can experience acute loneliness. These are factors directly associated with dietary inadequacy[7,8]. A program that can provide nutritious

food to this demographic group is therefore of the utmost importance.

OVERVIEW

For the 10-week pilot project starting June 5 and ending August 7, a total of 14 participants, all over the age of 65, have been recruited. Five participants are people with age-related loss of independence, referred by CLSC employees such as nurses or social workers. The other nine are community seniors, recruited through snowball sampling. As the project continues to grow, it is hoped that more seniors will be recruited each week.

The GFB program to be utilized by the CLSC René-Cassin is organized by Moisson Montréal, a food bank organization. The program started in the Notre-Dame-de-Grâce neighbourhood in 2003, and in September 2007, this community effort was expanded into a regional program[9,10]. Today, the GFB program delivers approximately 1,000 boxes per month to over 70 locations around the city. Deliveries occur every two weeks and participants can choose between large, medium and small boxes for $16, $10 and $7 respectively, saving between 20% and 50% compared to retail stores[10].

For this pilot project, the City of Côte Saint-Luc has allowed the Aquatic and Community Centre to be used as a drop-off location. The GFBs are delivered every Tuesday, after which participants can pick up their produce. Select participants or volunteers deliver boxes to those who are homebound. This way, isolated seniors get to enjoy fresh produce as well as a friendly visit. The contents of the box vary according to what is in season and reasonably priced at the time. Also included in the GFBs is a newsletter with nutrition and product information, recipes and food preparation tips.

Today, the GFB program delivers approximately 1,000 boxes per month to over 70 locations around the city.

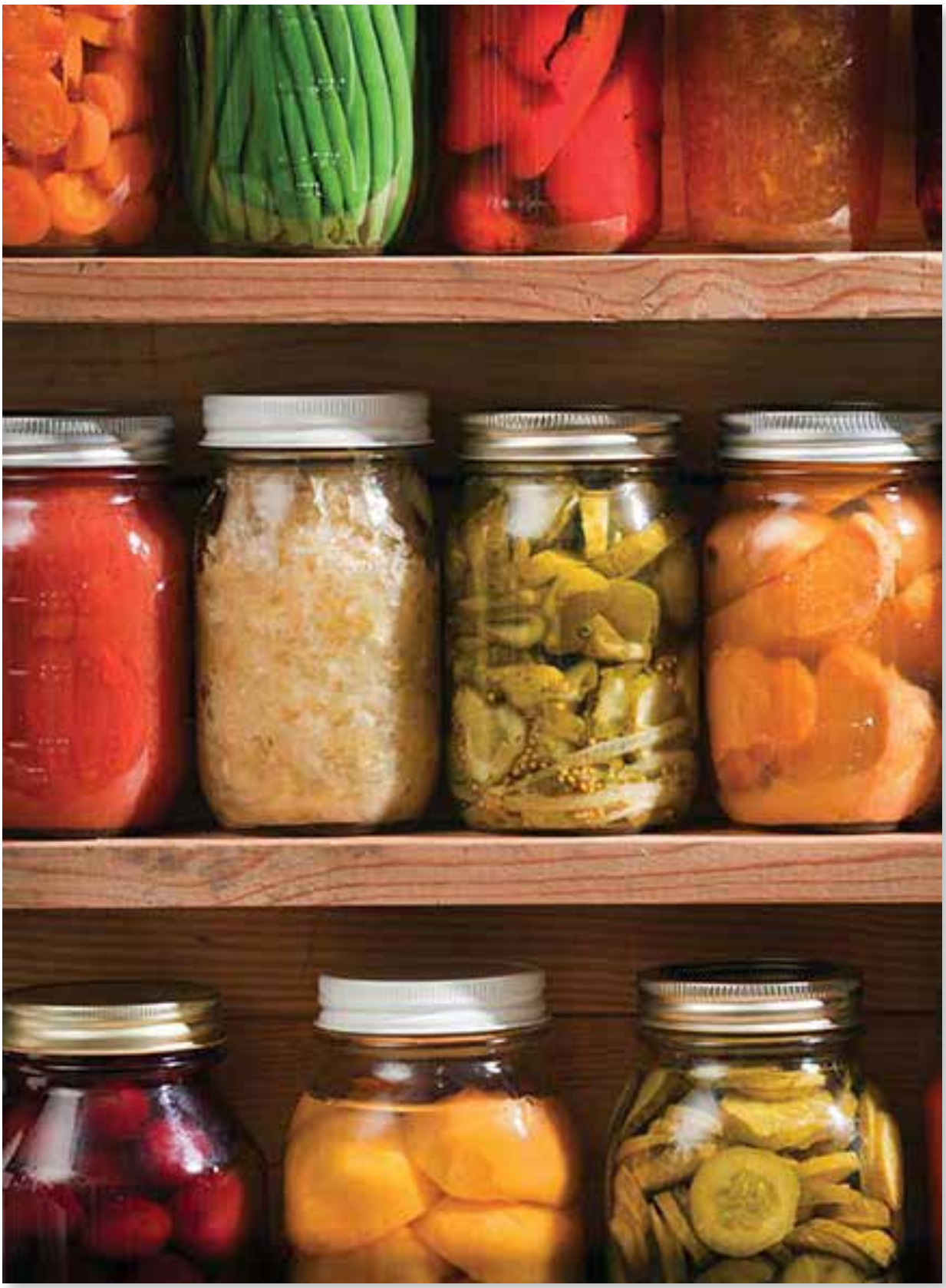
RESULTS

A baseline interview consisting of 15 questions was administered prior to the first delivery. Thirteen participants completed the interview and one was unavailable. Baseline characteristics revealed that 12 participants are female, one is male, 11 are retired, two are employed full-time, six live alone, and seven live with their partner. In terms of fruits and vegetables, eight felt they consumed enough produce every day, whereas four stated that they did not, and one was unsure. Mentioned barriers to eating more fruits and vegetables included laziness, lack of appetite, lack of mobility and preference for other foods. Although this age group should be consuming between 7 and 9 servings of fruits and vegetables each day[11], five participants only consumed between 0 and 3, seven had between 4 and 6, and only one had between 7 and 9. The majority of participants said they purchase their produce at the local IGA because it is convenient, yet interestingly, most who shop there commented on the high prices. This demonstrates that physical accessibility is an important factor in people's food purchasing habits.

After the first delivery, four participants dropped out. One stated that the GFB was a good idea, but that she did not like all of the vegetables and already had some of the items the box provided. Another also agreed that it was a nice concept, but that the box did not suit her preference for fruits and dislike of vegetables. Two more questionnaires will be administered: a mid-project questionnaire to evaluate the success of the program thus far in terms of logistics and interest, and another final questionnaire to determine any changes in fruit and vegetable consumption.

ELSEWHERE IN CANADA

Results from other GFB evaluations have revealed that this program does increase fruit and vegetable consumption. In Barrie, Ontario,



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70% of participants indicated that they ate more fruits and vegetables after joining the GFB program[12]. Similarly, in Saskatoon, 84% of participants reported an increase in both their own and their children's intake of fruits and vegetables[13]. One possible reason was the greater accessibility of produce, as indicated by 81% of participants in Barrie[12]. Another important benefit identified in these evaluations was a heightened sense of community[12]. These results provide ample justification for the CLSC René-Cassin's GFB initiative for the isolated elderly in Côte Saint-Luc.

LIMITATIONS

Even with significant benefits, some difficulties in implementing a successful GFB program are inevitable. For instance, previous evaluations have shown that participants often find it difficult to eat all the produce before it spoils, forget to order or pick up their GFB, or have difficulty accessing the drop-off location[13,14]. Another issue is the fact that participants are not able to select the produce in their box[9]. Because this pilot project targets the isolated elderly by providing a supplementary delivery service, it is hoped that barriers to accessing fresh produce will be overcome. However, some of the barriers mentioned in previous studies have also arisen in this pilot project thus far. For example, two of the participants who dropped out after the first delivery said they were unable to finish all the produce, and some participants who did not like certain items said they would appreciate being able to choose the contents of their box.

CONCLUSION & FUTURE DIRECTIONS

After successful completion of the pilot project, there is room to grow. It is hoped that the project will be expanded to encompass all Côte Saint-Luc residents who are interested in participating. It would also be beneficial to further cater to elderly participants by having volunteers cut and prepare the produce before delivery. Improving the nutritional and health status of residents as well as supporting local agriculture will have a positive impact on the quality of life of those in the community.

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"Seniors on the Move": An Exciting Intergenerational Workshop en effervescence

Agathe Lorthios-Guilledroit
Master's canditate in Community Health
Université de Montréal
agathe.lorthios-guilledroit@umontreal.ca

Manon Parisien *MSc*
OT(c) erg., Planning and Health Promotion Officer, Prevention, Promotion, Health and Aging team
CSSS – CAU Cavendish
manon.parisien.cvd@ssss.gouv.qc.ca

Kareen Nour *PhD*
Researcher in health promotion, Public Health Department
Agence de la santé et des services sociaux de la Montérégie
k.nour@rrsss16.gouv.qc.ca

Stéphanie Dupont *BA*
Community Organizer
CSSS – CAU Cavendish
stephanie.dupont.cvd@ssss.gouv.qc.ca

In Montreal, close to 38% of seniors use public transport. However, the use of public transport[1] poses several challenges in terms of community mobility because it involves carrying out a series of tasks that may prove difficult for seniors with functional limitations[2]. Many seniors have also noted difficulties encountered when sharing urban transport with youth. For example, some feel insecure in the presence of youth near metro stations[1,3] while others deplore the fact that young people tend not to give up their seats[4].

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Seniors in Montreal West have stressed the importance of having a public transport system that responds to their needs, primarily by promoting intergenerational respect and interaction. It was out of a desire to sensitize teenagers to the realities of seniors using public transport that the "Seniors on the Move" project came into being.

COURTESY IS EVERYONE'S BUSINESS!

In 2012, the NDG Senior Citizens' Council, in partnership with the CSSS – CAU Cavendish, developed an awareness workshop on the needs of seniors who use public transport. This short workshop for high school students was designed to be facilitated by senior volunteers. It also aimed to sensitize teenagers to the importance of courtesy when using public transport in order to improve the safety and comfort of seniors and, subsequently, to facilitate their mobility.

SPOTLIGHT ON AN INNOVATIVE APPROACH

The steps taken to design this workshop are part of the integrated co-construction process[6] used by the Prevention, Promotion, Health and Aging team at CSSS –CAU Cavendish to develop interventions in health promotion. This process consists of six main steps, the first four of which were carried out for this project.

Step 1: Definition of the project

We conducted a literature review in order to situate the main focus of the project (the courtesy of youth) in a larger context that takes into account factors limiting or facilitating the use of public transport by seniors. The databases consulted were Medline, Sociological Abstracts, Social Services Abstracts, ERIC and Google Scholar. Using 14 relevant articles, we were able to identify certain barriers to the use of public transport by seniors, most of which were tied to inadequate service quality: lack of information, infrequency of service, rough driving of some bus drivers or the physical environment (the distance to walk to a bus stop, steps at the front door of the bus[2,3]). To a lesser extent, the lack of courtesy of passengers was also mentioned[4].

However, the use of public transport poses several challenges in terms of community mobility because it involves carrying out a series of tasks that may prove difficult for seniors with functional limitations. Many seniors have also noted difficulties encountered when sharing urban transport with youth.

Step 2: Development of a flowchart and facilitation tools

We first identified promising interventions, noting best practices and available tools to sensitize teenagers to civic-mindedness and respect for others. In addition to searching databases, we reviewed the grey literature and found interesting interventions on public transport websites. Two examples of note are the "It's a good thing" awareness campaign run by the Société des transports de Montréal[7] and the "Permis mobile"[8] campaign developed in Belgium, both aimed at encouraging courtesy among public transit users.

The theory of planned behaviour[9] was used to develop a workshop flowchart. This theory of behavioural change is widely applied in health promotion. It explains that the intention to adopt a behaviour (being courteous to seniors) is influenced by attitudes linked to that behaviour (being courteous to seniors is desirable / undesirable), subjective norms (my family and friends believe that being courteous to seniors is important/not very important), and perceived behavioural control (it seems easy / difficult to be courteous to seniors). The individual will more likely adopt the behaviour if the attitudes and subjective norms are favourable to the behaviour in question and if the perceived behavioural control is great. In developing

the flowchart, we were able to draw connections between the theory of planned behaviour and the workshop components (goals, objectives, activities, tools, strategies). The exercise also enabled the project partners to agree on activities to be carried out.

The project partners included teenagers and seniors. Seven teenagers from Secondary 3 to Secondary 5 from different Montreal schools participated in a brainstorming session. They were asked what they thought of the topic and what workshop format they believed would be most appropriate for raising awareness about the needs of seniors and the courtesy of their peers towards seniors. In addition, six seniors who are members of a community organization participated in a discussion where they shared their opinions on the format and content of the workshop. Based on these consultations, the literature review, the theoretical model and the flowchart, we developed a preliminary version of the workshop facilitation guide.

Step 3: Validation of facilitation tools

The facilitation tools and a brief questionnaire were submitted to a validation committee for recommendations on the relevance and feasibility of the various intervention elements. An expert in knowledge transfer, an expert in seniors' mobility, two seniors, a teenager, a school professional, a community organizer, a health promotion researcher and an occupational therapist then reread the first version of the workshop facilitation guide. The committee's main recommendation was to restructure the guide in order to further highlight the theme of courtesy among teenagers. Another recommendation was to increase the time allotted to each activity. The intervention tools were adjusted according to these recommendations.

Step 4: Testing of the workshop

The workshop was tested in three Secondary 1 and Secondary 2 classes in two different schools. The purpose of this trial run was to determine the practical feasibility of the workshop activities and to verify the response of the teenagers. In total, 63 teenagers participated in these workshops and all activities were tested. The majority of teenagers thought they were interesting (47 out of 63) and confirmed that the workshop encouraged them to adopt courteous behaviours (52 out of 63). Suggested improvements included more activities and more time to carry them out. The testing process showed that the activities and workshop were feasible. All feedback was taken into account in the writing of the final version of the facilitation guide.

THE IMPACT

The co-construction process used to develop the "Seniors on the Move" workshop had both advantages and limitations. It allowed us to develop an intervention that was both feasible and realistic, as demonstrated by the testing. In addition, by collaborating with stakeholders (teenagers, seniors), we were able to share practices and knowledge related to the project. However, it is important to bear in mind that this collaborative process is time-consuming.

Our literature review revealed scant documentation of courtesy in public transport. Given the absence of comparable initiatives, we relied extensively on the expertise of partners in our choice of strategies and activities for the workshop and the development of facilitation tools.

The resulting workshop has the significant advantage of being facilitated by volunteers who are seniors. The strategy, based on multiplier agents, is congruent with the goal of seniors' empowerment, which is so important for health promotion. In addition, it allows the intervention to be carried out at a low cost. However, one of the limitations is that the workshop addresses only one factor tied to seniors' mobility in public transport (courtesy).

Ideally, the workshop should be incorporated into a more ecological and multi-faceted intervention in order to optimize the potential to produce observable changes with respect to this issue.

Thanks to the facilitation and implementation tools, to be distributed free of charge, the "Seniors on the Move" workshop can be easily reproduced. The French translation is currently in progress. It is hoped that this intervention will foster further collaborations between seniors' organizations and high schools. Although the impact of this workshop on the attitudes and behaviours of youth in public transport cannot yet be evaluated, we hope that the knowledge gained through this awareness-raising initiative will be applied in all areas of young people's lives and will lead to improved intergenerational sharing of public transport.

For more information on the workshop Seniors on the Move, please contact the **NDG Senior Citizens' Council** at **514-487-1311** or visit the website at: **http://www.ndgscc.ca.**

ACKNOWLEDGEMENTS

The authors thank Sheri McLeod and Freeda Khan for their support in the development of the project. Thank you to all those who collaborated on the project and to the seniors and teenagers who participated in the development and the testing of the workshop. The project was funded by the federal New Horizons for Seniors Program.

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A Senior-Friendly Municipality:

Rallying Together to Improve the Quality of Life of Seniors

Marie-Josée Dupuis

Master's candidate in Urbanism, Institut d'urbanisme de Montréal
Project manager for SFMA and assistant for transportation and mobility projects
Table de concertation des aînés de l'île de Montréal (TCAÎM)
concertation@tcaim.org

On March 1, 2011, the City of Montreal announced that it was adopting the Senior-Friendly Municipality Approach (SFMA) as a way to improve seniors' living conditions in the greater Montreal area. The action plan, to be revealed on October 1, 2012, on International Day of Older Persons, will propose various actions with regard to urban planning, housing, safe living conditions, civic engagement, communications, etc.

It is a process that comes with many expectations.

BASIS FOR THE PROVINCIAL PROGRAM

The original idea for the Senior-Friendly Cities Approach (SFCA) came from Alex Kalache, director of the *Ageing and Health* Program of the World Health Organization. The underlying principle consists of fostering active ageing in communities where seniors live by adapting policies, structures and municipal services[1].

According to the WHO, "active ageing" is the process that helps optimize possibilities, not only for ongoing participation, but also for good health and safety as a way to increase the quality of life during ageing[2].

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In 2005, during the 18th World Congress on Gerontology and Geriatrics held in Rio de Janeiro, Brazil, Dr. Kalache presented the idea for his program. Numerous international delegates showed interest in implementing this concept in their country. A large study was then conducted by various international collaborators who actively sought out the participation of 33 cities around the world, including Sherbrooke, Quebec. This, in turn, led to the publication of the World Guide on Senior-Friendly Cities on October 1, 2007[3].

In 2007, just as a public consultation on seniors' living conditions was being held in Quebec, the Minister Responsible for Seniors, Ms. Marguerite Blais, learned about the WHO project during a presentation made by Suzanne Garon and Marie Beaulieu, two researchers from the Université de Sherbrooke. The following year, in collaboration with the Research Centre on Ageing[4] at the Université de Sherbrooke, the Ministry of Families and Seniors (MFA) offered its support to a five-year pilot project, to be set up in six municipalities and in one regional county municipality (RCM). Since then, interest in the project grew to the point that almost 200 Quebec municipalities adopted the Senior-Friendly Cities' Seven Step Process, which later became, in Quebec, the Senior-Friendly Municipalities Approach (SFMA).

The 7 steps of the Senior-Friendly Municipalities Approach (SFMA) process:

- Obtain the approval of elected officials;
- Set up a steering committee;
- Conduct a diagnostic of the living environment;
- Write up an action plan;
- Implement the actions;
- Evaluate the process and actions on an ongoing basis;
- Write up a communication plan.

The arrival of SFMA in Quebec was met with enthusiasm by the Table de concertation des aînés de l'île de Montréal (TCAÎM). In 2009, the TCAÎM and the Montreal island chapter of the FADOQ Network united with elected officials and other community groups to raise awareness about the project. For example, a meeting of both local seniors' committees was organized on the SFMA theme in December 2009. In 2010, awareness-raising letters were sent out to the 19 boroughs and 15 reconstituted cities and a meeting was held with borough representatives. When the City of Montreal's intention to adopt the SFMA process was confirmed on March 1, 2011, the TCAÎM reiterated its wish to be one of the main spokesperson and act as a liaison between these authorities and seniors' community groups at the local and regional levels.

In this process, the role of the TCAÎM to act as a liaison and mobilizing force, begins first and foremost by disseminating information between municipal authorities and the community sector.

A DISTINCT PROCESS FOR THE GREATER QUEBEC AREA

The SFMA process is a collective project involving various municipal levels. It is at that level that the community sector, working on behalf of seniors as well as seniors themselves, need to be mobilized and consulted to make sure actions represent real needs. Through negotiations between the MFA and the City of Montreal and in light of its distinctive features, notably population density and political structure, the SFMA process was adapted to meet specific Montreal realities. One should keep in mind that in 2006, 246,045 seniors over the age of 65 resided in the greater Montreal area, representing 25% of all seniors in Quebec[5].

Following discussions with the MFA, it was understood that the city-centre would be responsible for implementing the seven steps of the process while the boroughs

TABLE 1

SOME OF THE THEMES DISCUSSED DURING THESE FORUMS	FREQUENTLY MENTIONNED
What are the main difficulties you encounter when you travel by foot, bicycle or motorized wheel chair?	Sharing the road with car owners at intersections and pedestrian crossings. The state of sidewalks, roads, public spaces, maintenance and obstacles on sidewalks, bicycle paths, streets and street furniture.
What are the main difficulties you encounter when you need to travel by public transportation?	The GOLDEN shuttles service is not available everywhere, routes do not necessarily correspond to the travel habits of seniors. Not feeling safe (the fear of being assaulted or of falling), keeping one's balance in the bus, service between stops is not always offered by bus drivers.
Why do you like your neighbourhood?	Nearby services: merchants, restaurants, libraries, pools, grocery stores.

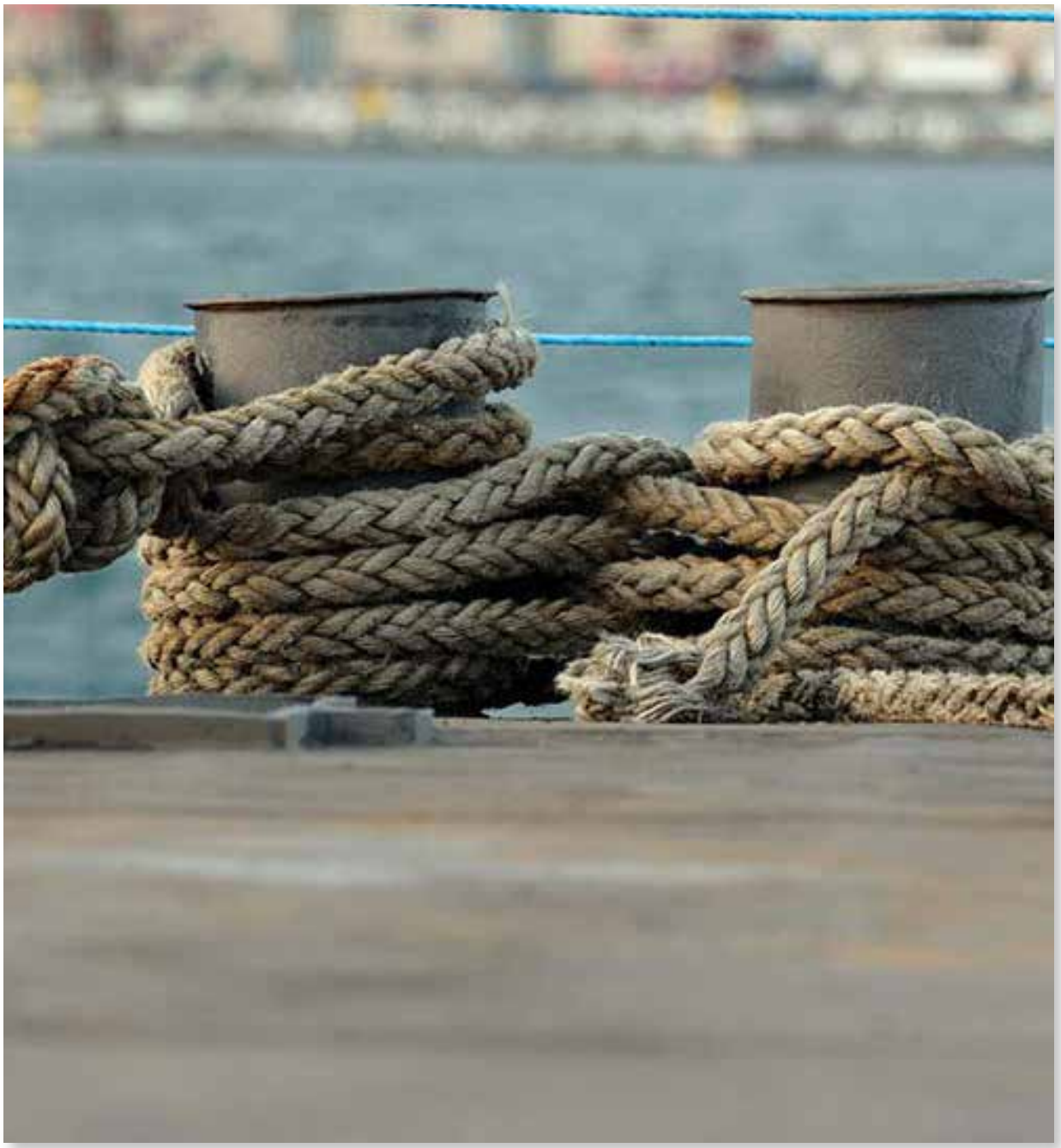
would participate by delegating their elected official responsible for seniors' to the City of Montreal's committee of elected officials. Besides this committee, the city-centre set up a steering committee made up of 26 representatives from different municipal executive offices, a committee of partners made up of key players from the community sector working with seniors (which includes the TCAÎM) and a committee dealing with communication and exchange on social development made up of the division heads from the 19 boroughs. So far, this organizational structure allows the various municipal levels and key players to be kept informed of the goals and vision of the city-centre.

In February 2012, following discussions between the City of Montreal and the committee of partners, it was decided to hold consultation forums on the needs of seniors in four strategic areas of the city, rather than just in the downtown area. By proposing to decentralize the consultation process, the committee of partners intended to facilitate the participation of seniors and local workers. Elected officials (5%), municipal workers (20%), seniors (26%) and representatives from the community sector (49%) were among the 272 people who joined together at these meetings[7]. Placed together in different workshops and discussion groups, they were able to establish priorities in terms of planning living and housing environments, city travel, safety and communications as well as culture, sports, leisure activities and social development (Table 1).

Throughout the spring, the Carrefour action municipale et famille (CAMF) and the City of Montreal analyzed the needs expressed during these forums, in order to determine what actions to take to adapt policies, structures and Montreal services. A projected action plan was made public at the end of May 2012 and citizens were invited to react to the document during two consultative meetings held in mid-June 2012. The City of Montreal and the CAMF considered all comments and recommendations made when writing up the final draft of the SFMA action plan, publication launched on October 1.

SENIOR-FRIENDLY MUNICIPALITY APPROACH, A PROMISING PROCESS

For several years, the TCAÎM has been involved in making the SMFA process known to elected official and the community sector, since it directly echoes the mission, principles and values of the organization. While developing ties with all age groups, the TCAÎM has offered Montreal seniors' groups a place to exchange on ways to improve the quality of life of older citizens. To better understand their needs, it is essential that municipal authorities consult seniors and local organizations in their territory while following up with the appropriate steps to improve the quality of their environment.



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Today's seniors are not a homogeneous group; they reflect, rather, many differing realities. Ageing is different if one is a man or a woman, if one is in good health or has functional restrictions, etc. In this sense, the TCAÎM applauds the integrating principles as defined by the City, in order to guide actions with respect to universal accessibility, partnership and collaboration, building on what already exists, etc[6]. A Senior-Friendly Municipality is a promising initiative with short, medium and long-term effects that will benefit all generations, as long as the actions that are taken represent local needs. It is an opportunity to take the more inclusive, intergenerational road that is required.

In this process, the role of the TCAÎM to act as a liaison and mobilizing force, begins first and foremost by disseminating information between municipal authorities and the community sector. Some communications tools aimed at giving out clear information on how this process is unfolding have been created. A web page devoted to SFMA on the organization's blog, has been online since February. Some blog posts have been written on this subject and at the end of May, the newsletter "Ensemble pour une île amie des aînés" was launched jointly with the Montreal island chapter of the FADOQ Network. With these tools, the TCAÎM promotes examples of what has been accomplished in the Montreal area as well as proposed projects that are within the spirit of SFMA, in order to rally together as many players as possible around this project.

UPCOMING CHALLENGES

On October 1, 2012, when the launch of action plan is made public, the City of Montreal was certified as a Senior-Friendly Municipality. Many challenges still lie ahead, namely obtaining adequate funding from the provincial government to implement the proposed actions. Right now, no financial support has been confirmed. Another challenge ahead is the fact that the boroughs do not have to join the process even though the needs that were expressed in the first steps of the process have been linked to the local level. Once again, the question of funding remains crucial, in order to conduct a profile of the territory and implement an action plan. For the TCAÎM, Montreal's commitment to SFMA is seen in a favorable light and our role as a mobilizing force and liaison between municipal authorities and the community sector makes us a key player and places us in a position to see this integrated process accomplished. In this sense, we are counting on the City of Montreal to make sure that we have a place on the monitoring committee, in order to continue to support the priority needs of Montreal seniors and to see to it that conditions are met for ageing well in city.

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Living at Home

Conversation between Patrick Durivage, Social Practitioner at CLSC René-Cassin, and Mrs. Benarrosh, a Côte St-Luc resident and home care services recipient from the CSSS–CAU Cavendish.

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P.D.: Mrs. Benarrosh, thank you so much for granting us this interview for Pluralages.

Mrs. B.: It's my pleasure.

P.D.: So, you've been living here for a long time?

Mrs. B.: You mean in this apartment? Since the 1980s, so it's been about 25-26 years.

P.D.: You used to live here with your children before?

Mrs. B.: No. My children bought this condo for me. First, I became widowed at a very young age and I had absolutely nothing, nothing. My husband left me a house, that's all. I sold the house and that's how I created a shoe business in Meknès, Morocco. I worked and when we came here, we didn't have anything, we left it all there. I came to Canada with my children. We had nothing and so we were renting.

I lived in a house with my children. Then the oldest got married, then the second child got married, and everyone left. I found myself alone in a big house. It was too much. So they gave me the choice.

I visited Côte St-Luc and I liked it. I looked for over a year! And then I found this apartment. They liked it. They bought it for me, and it has been the greatest gift of my life. They bought this condo for me 25 years ago.

P.D.: What do you appreciate the most about this home?

Mrs. B.: You see? It's wonderful. It is very central. The building is quiet and calm. Everyone respects one another. No arguments. Nothing. We talk to everyone here and everyone likes you. There, I like that: the friendly neighbors.

P.D.: Would you like to make changes to it? A better equipped kitchen? With lower cupboards, to have space for a chair to sit and cook?

Mrs. B.: At my age, we don't like change very much. The ceiling sometimes gives me trouble, so when there's a draft… anyway, it's old! This is an old building, almost 35-40 years old. One of the first condominium buildings in Côte-St-Luc.

P.D.: How long have you been receiving the services of the CLSC?

Mrs. B.: It's been about 10 years. After my first stroke. And that was 12 years ago.

P.D.: Which services do you receive from the CLSC?

Mrs. B.: A lady comes once a week to give me a bath and the cleaning lady comes to help me once in a while as well, and she also cooks for me. I don't need very many things. The groceries on Saturday for my children and for the rest of the week.

I am followed by Dr M, she is wonderful. I love this girl, she's perfect! As a matter of fact, my daughter Penny also has her as her doctor.

I have also had the services of a social practitioner, you, for a long time! My children speak very highly of you! One can do nothing but respect you and love you, really!

P.D.: Tell me about an encounter or an event that you remember happened with one of the intervention workers of the CLSC.

Mrs. B.: The day you called in all my children for a meeting. They all came, and you were with Dr M, and it was a wonderful day because my children met you, and really appreciated you… and I was very proud to introduce you to my children!

It was a friendly meeting to discuss my needs in terms of homecare. Did I want to stay in my home or move to a residence? We discussed it and then I said: "I'd prefer to stay in my home, with services". And I'm delighted by all the services that I receive at home. I am satisfied. Now, they have referred me for a few more services because I depend on others for many things. But let's not exaggerate, because there are far worse situations than mine, there are people with greater needs.

P.D.: Well, Mrs. Benarrosh, thank you so much for your time.

Mrs. B.: You're welcome. It was my pleasure.

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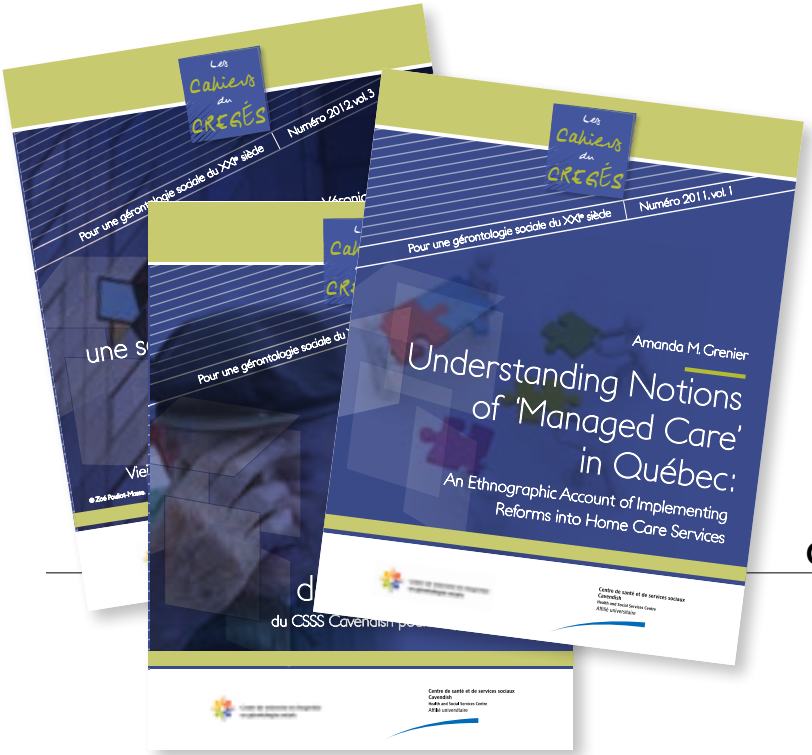

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