Sustainable Home Support for Seniors in New Brunswick: Insights from Seniors and Social Workers

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1. Executive Summary

The proportion of the world's population over the age of 65 will reach 14% by 2040 and population aging is even more acute in New Brunswick where the proportion of the population over 65 had already reached 15% by 2005 and is predicted to rise to almost 26% by 2026 (Kinsella and He 2009, Stats Can 2006a). New Brunswick boasts the highest per capita provision of home support and the highest percentage of seniors in Canada receiving home support (CIHI 2007; MacAdam 2008, 2009). While New Brunswick makes a distinction between home support and home care (extra-mural medical services), seniors are able to access both types of services through a "single point of entry" into the system (Di Matteo and Di Matteo 2001:315). Home support is as important, if not more important than medical services in enabling seniors to remain healthy and independent (Hollander and Prince 2007, Nugent 2004), and home support is more cost effective than institutional care in the case of seniors without serious health problems (Hollander et al. 2009a).

1.1 Methodology

Fundamental to creating evidenced-based policy aimed at improving home support for seniors is understanding how seniors themselves are assessed for and experience the services they receive (Shapiro and Havens 2000).Thus, we used semi-structured, face-to-face interviews with 24 seniors (4 men and 20 women) as a primary means of generating data. Their ages ranged from 65 to 94 with half between the ages of 80 and 94. Seven (7) of these seniors identified as Francophone and 17 as

Anglophone. Equally important in contributing to evidence based policy is understanding how front line workers experience provision of home support services for seniors. Therefore we conducted focus groups with 11 social workers involved in the assessment and case management of home support for seniors in New Brunswick. Ten (10) were women, reflective of gender segregation in the profession of social work (Olson 1994). Only 4 of the social workers we were able to recruit were Francophone, far fewer than the 56.5% of social workers in the province as a whole (Stats Can 2011c). Both the seniors and social workers who took part in this research were recruited through the Department of Social Development, Government of New Brunswick. We also analysed demographic data on the 4289 seniors currently listed as receiving home support in New Brunswick which provided us with important contextual information (Silverman 1998). Working in partnership with the Department of Social Development, Government of New Brunswick, the overall goal of this project was to produce knowledge which informs evidence-based policy aimed at improving the effectiveness and sustainability of home support for seniors in the province.

1.2 Successful Daily Life

In many respects successful daily life is no different for those over 65 years of age than it is for those under 65. We all need to feed and clothe ourselves; keep our houses clean; and deal with shopping and other daily tasks, however, how we accomplish these tasks can change as we age. We found that seniors are able to accomplish the activities crucial to successful daily life when they are able to weave together systems of formal home support and extra mural health care services with

informal support networks made up of family, friends, and neighbours. All the seniors who took part in this research were, in general, happy with the home support services they receive. Most had homemakers or personal care workers who were locally based and almost all were very happy with their home support workers. A ‘good’ homemaker is someone who knows exactly what needs to be done without being told and is one that seniors can establish a relationship with. Problematic homemakers are those who need to be told what to do, are unreliable, and/or behave unprofessionally. Home support workers with formal skills training is of particular importance for seniors who need personal care. Seniors were dissatisfied with the frequency with which homemakers are changed. Many of these seniors also told us that their needs go unmet because of agency rules that govern what home support workers can and cannot do.

Another part of the formal support the seniors we spoke with depend on is technology. While very few had computers or used the internet, many banked by phone and used other types of technology. Almost all other seniors who participated in this research used some form of Lifeline monitoring systems and some told us they were very satisfied with it, however, others didn’t wear the device regularly because it is too easy to set it off by accident and others still found the device irritated their skin. Several seniors didn’t use Lifeline at all because of its cost. Thus a structural factor that mitigates against a senior’s ability to coordinate informal and formal networks of support is poverty. Low income seniors are most dependent on home support and over half of seniors who receive home support in New Brunswick have incomes so low that they receive the Guaranteed Income Supplement (Mather et al 2011, Raphael 2007).

1.3 Transportation

Seniors identify transportation as among their most important needs and transportation is crucial to their ‘quality of life” and sense of personal autonomy (Smith and Sylvestre 2001, Turcotte 2006:43). Over half of the seniors who took part in this research told us they still drive. A few of the seniors who could not drive themselves said that their homemakers would drive them to medical appointments or to go grocery shopping, however, homemakers are not permitted to transport clients in their vehicles unless they are covered by special insurance. Saint John is the only municipality in New Brunswick to provide accessible transportation through the public transit system and a patchwork of 21 different organizations provide accessible transportation for seniors and people with mobility impairment in other, but not all, parts of the province (PCSDP 2011). For some seniors, taking a taxi is a viable option to meet their transportation needs, however, taxi fare is beyond the financial means of many seniors we spoke with. Seniors in Atlantic Canada lack adequate access to transportation and publically funded forms of accessible transportation are also “typically under resourced” (PCSDP 2011:iA, Shiner et al. 2010). A lack of transportation is even more acute in rural parts of the province where 38% of New Brunswick seniors who receive home support reside (Mather et al. 2011). While transportation is nominally an item on the menu of home support services in New Brunswick, the social workers who took part in the focus groups told us that it is something they are rarely allowed to approve for their clients.

1.4 Housing & Living Arrangements

Seniors prefer to stay in their own home whenever possible (Sarma et al. 2009, Shiner et al. 2010).The seniors we spoke with lived in a variety of types of housing offering differing levels of informal and formal support including: family homes; apartments and condominiums; seniors only housing, and retirement communities; in addition to assisted living residences. Seniors living alone in their family homes are responsible for needs not met by home support services such as home repairs and snow shovelling. Those living in apartments not only had fewer household responsibilities but also had the added benefit of friends and neighbours in the building who would help them and look out for them. Retirement communities vary greatly but most provide some communal services for residents such as snow removal and activity centres and some are rent controlled and restrict residence to older people without small children. Seniors who reside in assisted living facilities have access to a variety of services provided to them such as: laundry; snow removal; meal preparation or cafeterias; health care services; transportation; and activity centres. An innovative idea that came out of the focus group discussions was the suggestion to use foster families to address situations where seniors lack informal support systems, particularly in rural New Brunswick.

1.5 Issues in Case Management & Assessment

At the same time case managers and/or assessors are engaged in determining appropriate services for their clients, they are also engaged in managing system resources, goals that can be difficult to reconcile, thus the social workers we spoke with

advocated home support assessments that are needs-based (Janlöv et al. 2006). An aspect of the assessment process these social workers found limiting is that for seniors to be eligible for home support they had to disclose three unmet needs of daily living, a criteria some social workers found arbitrary in that it didn't recognize cases of legitimate need. They also found the menu of services they use in assessments to be overly rigid and one which didn't allow them to address client needs in an effective way. These social workers want to be able to exercise discretion within a set budget as a cost effective way of better serving client needs. Also at issue is the split between case management and assessment, which social workers told us lead to: confusion for both clients and case managers; unnecessary delays; loss of information; and more costs to the system. It also adds to case managers' workloads. All but one of the seniors we interviewed for this research told us that there had been no follow up on their initial assessment and the social workers who took part in the focus groups told us that regular and on-going follow up in is impossible given the size of their caseloads.

1.6 Rural Home Support

Delivery of home support services in rural areas is challenging (Hollander and Prince 2007) and is a particular issue in New Brunswick where almost 50% of the general population live in rural parts of the province (Dandy and Bollman 2008, GNB 2006b). Most difficult is recruiting and retaining support care workers (Petitpas-Taylor 2009; VON 2008), a difficulty compounded by the time and money home support workers often spend on travel, problems made worse by road conditions in winter (Skinner et al 2009). These and other issues associated with the delivery of home

support in rural New Brunswick, including: the dearth of community groups and programs for rural seniors; out-migration of youth, as well as travel costs and other transportation problems, were identified by the social workers we spoke with. In addition to the problems of low pay and travel costs is that home support agencies are reluctant to supply workers for rural areas unless they are guaranteed a minimum number of hours, often an amount of time that exceeds what a senior is assessed for. This is also a lack of community programs and services for seniors in rural regions of the province. Moreover, there is a lack of transportation in rural areas, making even common everyday services less accessible for seniors in rural areas (Thompson and Postle 2007). Other infrastructure lacking in rural areas of New Brunswick is internet access.

1.7 Client Directed Home Support

New Brunswick currently offers a form of client-directed care where seniors determine hiring and firing of workers, although family members may not be hired (Spalding et al. 2006). Clients then submit hours and workers are paid through the Long-term Care Program. Client-directed home support allows service users to play an active role in directing the nature and type of care they receive and is argued to lead to positive outcomes among users including fewer unmet needs (Carlson et al. 2007, Clark et al. 2007). Under these models, the client must also manage a budget and take on the administrative responsibilities that accompany client-directed approaches, and these were not tasks most of the seniors we spoke with wanted to take on. Seniors more willing to perform the administrative tasks associated client-directed approaches are typically younger and have prior experience in managing workers. Those social workers

who provide service in rural parts of the province supported this kind of client–directed care and almost all of the seniors we spoke with, who had family members available, would like to have them provide home support rather than being required to accept an agency worker or other stranger. Some social workers were critical of any model where family could be hired, suspecting that such arrangements were more vulnerable to fraud, however, other social workers pointed out that “the same thing can happen with agencies too” (SW4, FGA). Moreover, rigorous research demonstrates that there is actually little incidence of fraud and abuse when consumers receive a budget and pay their own providers, whether providers are family or non-family (Benjamin 2001). None-the-less, the social workers we spoke with stressed that “there has to be some accountability” (SW6, FGB) in client-directed service provision.

1.8 The System

The social workers who participated in this research expressed a need for more standardization; additional financial and human resources; and better co-ordination with other departments or services in the Long Term Care System. They told us that the system was more efficient when all assessment tasks were handled regionally and when the financial assessment was not de-coupled from the needs assessment. They also expressed concern that while assessment tools and polices are standardized provincially, they experience a lack of standardization of regional office procedures making it more time consuming to sort out paper work on the cases they manage. They also told us that seniors receive forms they find confusing and cannot fill out on their own, necessitating a second trip made by a social worker or case manager in order to

give them the help they need. In addition, social workers said that the interactive voice response (IVR) telephone system that seniors must use to contact the Department can also be a source of confusion for seniors. Almost all social workers argued that the home support system is underfunded and some said that they favoured more spending on home support and less on institutional care. Research demonstrates that home support is more cost effective than institutional care in the case of seniors without serious health problems even when informal caregiver time is valued at replacement wage (Chappell et al. 2004, CIHI 2007; Hollander et al. 2007, 2009a). Social workers also told us that, where services were being supplied to more than one member of a family, money could be saved by using a 'family focus' rather than an 'individual focus.' Another systematic issue the social workers we spoke with raised is what they understood as "a disconnect" (SW11, FGB) between the LTC program and other services and departments they expressed the view that the underfunding and lack of resources they experience in their work reflect that long term care for seniors is not among the top priorities in the provincial social safety net, and is a program valued below extra mural health care as well as adult and child protection services.

1.9 Recommendations

1. Invest in home support as a cost effective alternative to nursing home care.
2. Ensure continuity of home support workers over time.
3. Require different and appropriate levels of skills training for homemakers and personal care workers.
4. Support investment in accessible transportation for seniors.

5. Support a variety of housing options for seniors who receive home support.

6. Replace menu driven assessment with needs based, client-centred assessment.

7. Re-couple assessment and case management duties.

8. Support Social Workers so they are able to conduct biannual follow-up with clients.

9. Allow hiring of family members to provide home support.

10. Evaluate the financial assessment procedure to ensure equity of client contributions.

11. Work toward better co-ordination between the Long Term Care program and other overlapping programs and services.

2. Introduction

The proportion of the world's population over the age of 65 will reach 14% by 2040 and the social impact of aging populations has been well documented (Kinsella and He 2009). There are many potential positive benefits of aging populations such as the growth of the voluntary sector (Bass and Caro 1996) and the impact of improvements in "life expectancy and health status, which may be present in an aging population [and] could contribute to strong GDP growth" (Andrews 2007:12, Mérette 2002; Manton et al. 2007). However, there are also significant challenges that accompany the aging of populations (Andrews 2007, CHCA 2008a, Denton et al. 2005, Légaré et al. 2008, OECD 2006). While it is clear that population aging is a critical global phenomena, the challenges posed by an aging population are even more acute in New Brunswick where the proportion of the population over 65 had already reached 15% by 2005 and is predicted to rise to almost 26% by 2026 (IFA 2008, Stats Can 2006a). Moreover, the dependency ratio in New Brunswick will reach 50:8 by 2040 (Mérette 2002).

In this report we present findings from our study of home support services for seniors in New Brunswick. In this research we analysed the experiences of seniors receiving home support and the experiences of social workers involved in the case management and assessment of those services. Working in partnership with the Department of Social Development, Government of New Brunswick, the overall goal of this project was to produce knowledge which informs evidence-based policy aimed at improving the effectiveness and sustainability of home support for seniors in the

province. This is a critical goal because a principal and recurring finding of the literature on home care and home support is that almost all seniors prefer to stay in their own homes whenever possible (CHA 2009, CHCA 2008b, Crowell et al. 1996, HCC 2008, McCann et al 2005, Sanders et al. 2005, SD/DS 2009, Shiner et al. 2010). Further, home support is as important, if not more important than medical services in enabling seniors to remain healthy and independent (Hollander and Prince 2007, Nugent 2004), and home support is more cost effective than institutional care in the case of seniors without serious health problems (CHA 2009; Chappell et al. 2004; CIHI 2007; Forbes and Janzen 2004; Hollander and Chappell 2002; Hollander et al. 2007, 2009a; Shapiro and Havens 2000, VON 2008).

2.1 Home Support in New Brunswick

New Brunswick spends more in home support than any other province in Canada and, at $156.35 per person, ranks among the highest in the country in per capita provision of home support (CIHI 2007:18; MacAdam 2008, 2009). Moreover, between 1995 and 2004, it was the only province in Canada that showed a “stronger growth rate for home support than home health care” (CIHI 2007). Of particular relevance, it boasts the highest percentage of seniors in Canada receiving some form of home care or home support (MacAdam 2008, 2009). In particular, New Brunswick has been praised for its “centrally coordinated homecare system with regional/decentralized delivery units” (Casey 2007, Hrabluk 2002, Di Matteo and Di Matteo 2001:315). While New Brunswick makes a distinction between home support and home care, seniors are able to access both types of services through a “single point of entry” into the system (Di Matteo and Di

Matteo 2001:315). Home care refers to extra-mural health care services and home support includes “non-professional assistance” with “personal care, activities of daily living, and home management” (SHAS 2009:34, SD/DS 2009:8). Approximately 4300 seniors currently receive home support services in New Brunswick (SD/DS 2009). The province follows a “public-professional and private home support model” where almost all services are obtained from private providers (Anderson and Parent 2000:5; SD/DS 2008). These may be “private individuals” but may not be members of a client’s immediate family (IFA 2008:3). Levels of support are calculated in units of hours rather than being cost based and the maximum level of home support is 215 hours per month (CHCA 2008a, SD/DS 2008). In 2007, New Brunswick changed its policy on client contributions to a net income-based test, consequently: assets, such as a senior’s home, are no longer part of the calculation (IFA 2008, SD/DS 2008). Clearly, New Brunswick has invested in home support services and provides a laudable level of support to seniors in the province. However, questions about the sustainability of this system have been raised in the face of New Brunswick’s aging population (Nugent 2004, UNB 2005). As of March 2011 the province of New Brunswick provided home support to 4289 seniors over the

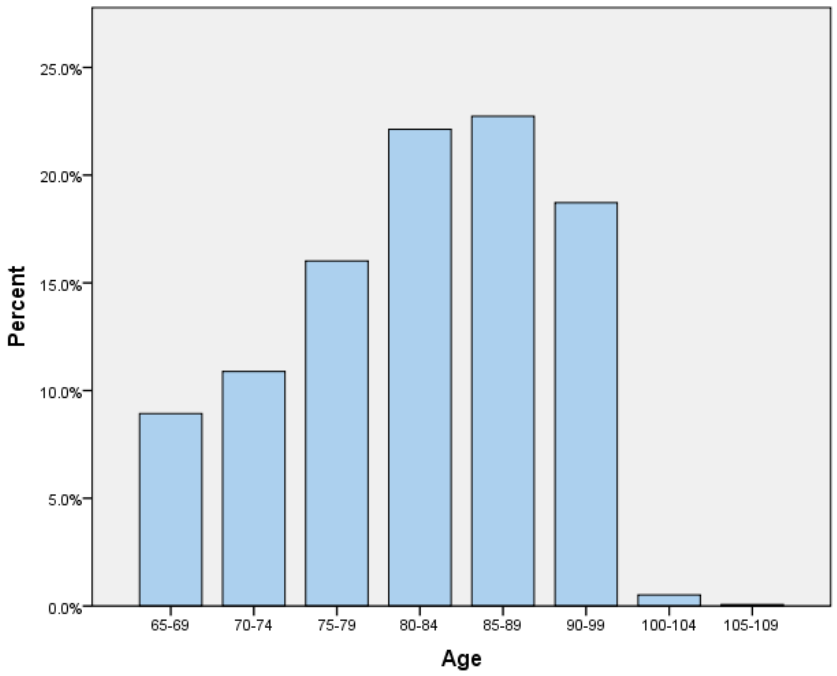

Chart 1 – Age (N = 4289)

age of 65. The ages of seniors receiving home support range from 65 to 109 and the bulk (45%) are between 80 and 89 years of age (See Chart 1). Women make up 77% and men 33% of the total number of seniors who are clients of the long term care (LTC) program, as is the case throughout Canada (Stats Can 2006b).

66% of seniors who receive home support in New Brunswick are Anglophone, 34% are Francophone (Stats Can 2011a) and most Francophones are concentrated in Moncton and in northern regions of the province. Both are reflective of how language is distributed in New Brunswick as a whole (See Table 1).

Region	English	French	Totals
Chaleur	34	66	100% (242)
Edmunston	7	93	100% (327)
Fredericton	99	1	100% (903)
Mirimachi	64	36	100% (431)
Moncton	55	45	100% (814)
Peninsula	1	99	100% (331)
Restigouche	51	49	100% (257)
Saint John	100	0	100% (980)

Table 1 - Language by Region (N= 4285)

A persistent finding in research on aging and socio-economic status is that low income and poor seniors experience lower health status, and are thus more dependent on home support and home care services (Angus et al. 2005, Davin et al. 2009, Keigher 1999, Plouffe 2003, Raina and Wong 2002, Raina et al 2000). Thus it is not surprising to find that in New Brunswick that over 50% of seniors who receive home support in this province rely on the Guaranteed Income Supplement (GIS) and live on very low incomes. Female seniors who are clients of the LTC program make due with even less than male seniors in New Brunswick who have a net monthly family income $241 higher

than female seniors. Again reflective of research showing this to be a problem in New Brunswick where almost 7% of seniors over the age of 65 live in poverty (NBACSW, 2008). Seniors living in rural regions of New Brunswick also live on lower incomes. Those living in the larger cities of Fredericton and Saint John have average and median monthly net family incomes that are larger than the other regions. All other regions have median monthly net family incomes that range from $1310 to $1397 except for Chaleur and the Peninsula where the median monthly net family income is just over $1250. The lowest average and median monthly net family incomes in the province are found in Chaleur. These findings reflect low-income rates in the province in general where "poverty rates are higher in non-metro-adjacent" (Stat Can 2011b).

Over 50% of New Brunswick seniors who receive home support live alone, 21% live with a spouse, and 18% live with family member(s). Only 2% live with people other than family members. 62% of the women who receive home support services live alone as compared to 49% of male seniors and more male clients (35%) live with a spouse than do female seniors (16%) who receive home support (see Chart 2). Neither finding is surprising given the higher life expectancies and thus higher likelihood of widowhood for women worldwide (Clarke 2008; van den Hoonaard 2009, 2010).

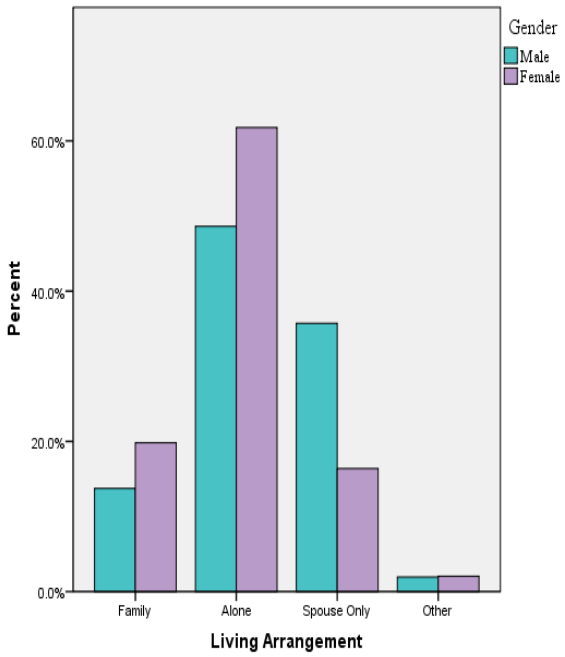

Chart 2 - Living Arrangement by Gender (N= 4236)

Of particular interest are the differences in living arrangements of seniors who receive home support across the different regions of the province. For example, those living in the rural and largely Francophone areas of Chaleur, Edmunston, Peninsula, Restigouche are least likely to live alone and those living in the larger, mostly Anglophone centres of Fredericton, Moncton and Saint John are most likely to live alone (See Table 2). This pattern can be explained by lack of rural infrastructure transportation, community centers and other services in rural areas (Thompson and Postle 2007), and by the fact that despite the outmigration of young people from rural New Brunswick, there are still families who reside there and rural and Francophone cultures are more communally and family oriented (Baer and Curtis 1984, Beale 2008, McCann et al. 2005).

Region	Alone	Family	Spouse	Other
Chaleur	5	6	7	0
Edmunston	8	6	7	27
Fredericton	21	17	22	29
Mirimachi	10	12	10	6
Moncton	20	16	20	12
Penisula	6	14	8	7
Restigouche	6	7	6	6
Saint John	24	22	20	13
Total	100% (2462)	100% (771)	100% (877)	100% (85)

Table 2 – Living Arrangement by Region (N=4289)

The types of home support services seniors may receive include: adult sitter; attendant care; clinic-specialized health; day centre; friendly visiting (volunteer); home health care or supervision; home security alert; homemaker; housekeeping; intervention or support services special health groups; life skills or self care day programs; meals on

wheels or wheels to meals; medical service; parent aide, respite care, or family support worker; relief care or short term placement in special care home; sheltered employment or workshops; taxi, private transportation; public transportation; volunteer transportation; equipment or health supply or assistance; and/or wheelchair transport or hydraulic lift. However, the type of home support service provided to over three quarters (77%) of seniors in New Brunswick is some form of homemaking or housekeeping.

The LTC program funds 91% and seniors themselves contribute 9%, of the average total monthly costs of their home support services. As small as their proportion of contribution is, it represents a significant part of the monthly budget for the seniors we spoke with. For example, according to Linda, one of the seniors who took part in this research, the biggest problems that she experiences as a senior trying to live independently is the high cost of living and that the amount she pays for her home support services. While to some the amount may seem negligible, for a senior living on a fixed income it is too high for her to manage comfortably. In her words: “It seems that okay they pay a portion of it, but I still pay quite a bit. I still pay over $40 a month for 6 hours” of homemaking services. While the seniors we spoke with said they are very happy in general with the home support services they receive, they also told us about a number of ways in which their needs were not being met. We discuss the reasons for these unmet needs and make recommendations for amending policy to address them. Such research has never been more important as populations continue to age and governments make efforts to maintain the home support services that enable seniors to live healthy, independent, and productive lives.

3. Methodology

Fundamental to creating evidenced-based policy aimed at improving home support for seniors is understanding how seniors themselves are assessed for and experience the services they receive (Chappell 1994, Dill 1990, Shapiro and Havens 2000). Thus, we used semi-structured, face-to-face interviews with seniors as a primary means of generating data as this is a method of data collection that ensures that the focus remains on the informant, emphasizing “the value of the person’s own story” and because it also allows the researcher to gain an interpretive understanding of the motives and meanings behind the actions of individuals (Becker 1966:vi, McCraken 1988).

Equally important in contributing to evidence based policy reform is understanding how front line workers experience assessment and case management of home support services for seniors. Therefore we conducted focus groups with social workers involved in the delivery of home support to seniors in New Brunswick. We used the technique of low moderator involvement in facilitating the focus group discussions meaning that while we did introduce specific topics, discussion was not limited to those topics, rather we concentrated on listening to what the members had to say, interjecting as little as possible (Morgan 1988). We also analysed demographic data on the 4289 seniors currently listed as receiving home support in New Brunswick, which provided us with important contextual information (Silverman 1998).

3.1 Recruitment

The method of recruitment we used in this project was most analogous to the "Health Services" model of recruitment, a situation where a health service provider or agency provides contact information and/or client or patient lists to the researchers, or do the recruiting on behalf of the research team (UyBico et al 2006:853). Both the seniors and social workers who took part in this research were recruited through the Department of Social Development (SD/DS), Government of New Brunswick who provided us with the names and contact information for all seniors (aged 65+) currently receiving home support services and for all social workers involved in the assessment and case management of home support for seniors in the province. Purposeful sampling was then employed in selecting key informants from those populations (Curtis et al. 2000, Burgess 1989). For example, since gender, region, and language are important variables in this research, we made efforts to include individuals representative of those social categories. Moreover, because more women than men receive home support we purposefully recruited more women than men. Given the concentration of Francophones in rural areas in New Brunswick, language was also an important variable to be considered thus we made sure to purposefully target Francophone seniors in recruiting participants for the interviews (FCFA 2004). We recruited seniors and social workers from all regions in the province (See Figure 1) and all focus group members had at least some, if not extensive, experience in working with seniors living in rural areas of the province.

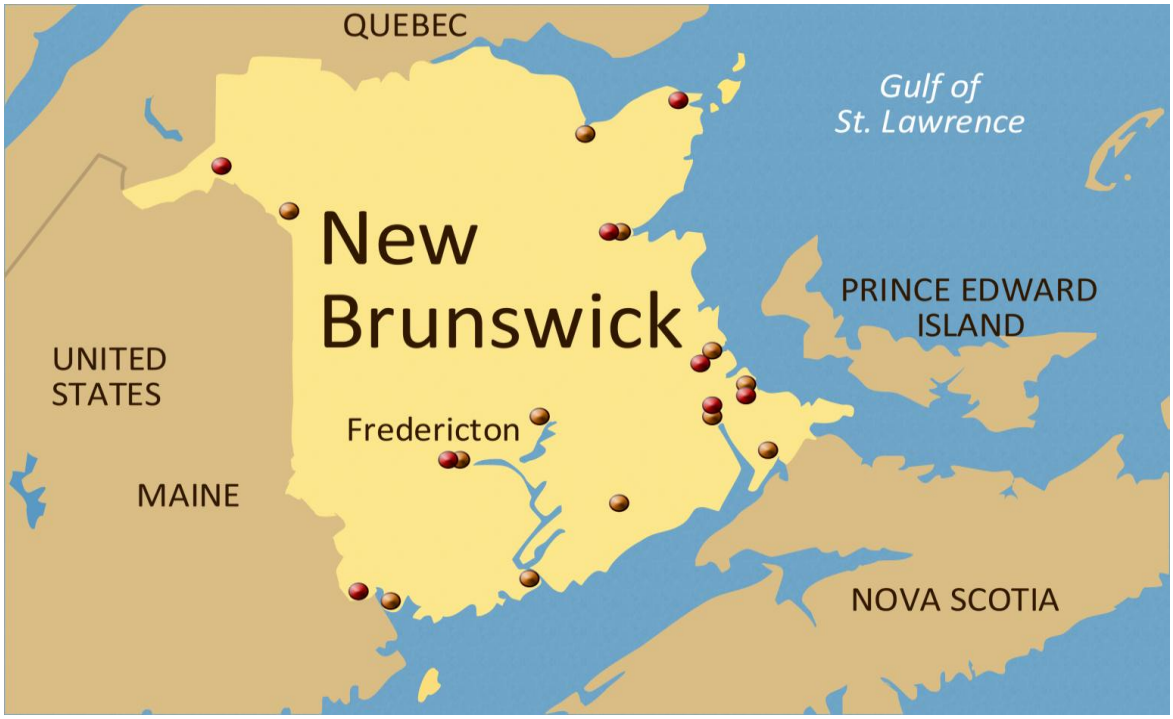

Figure 1 – Recruitment Locations

3.2 Data Analysis

The data collected in this research was analyzed thematically via comparative coding where analysis is conducted concurrently with data collection. This approach allows the researcher to note themes and patterns which emerge from the analysis, compare them, link them conceptually with one another, and use them to guide the subsequent foci of data collection and analysis (Ryan and Bernard 2003, Corbin and Strauss 1990, Trow 1970). Another aspect of comparative coding is on-going theoretic sampling of the literature whereby emergent themes in the data suggest particular areas of the literature for review (Corbin and Strauss 1990). It is also an assumption of this research that the unit of analysis in this case is the concept, not the interview or participant (Corbin and Strauss 1990).

3.3 Validity, Reliability & Generalizability

Comparative coding was the mode of analysis in this research. This method of coding bolsters the validity of the analysis via the constant comparison of a series of interviews, where each interview serves to validate or refine the conclusions drawn from the data collected in the others (Corbin and Strauss 1990, Trow 1970). Validity in this research likewise rests on the richness of the data collected. The sheer amount of information to be provided by the research participants results in such "detailed data [that] they counter the twin dangers of respondent duplicity and observer bias" (Becker 1970:52). In addition, the validity of the analysis is strengthened through on-going theoretic sampling of the literature which grounds emergent findings in prior research and through research participant review of the analysis which ensures that the findings reflect the experiences and perceptions of the individuals who took part in this research (Corbin and Strauss 1990, Johnson 2002).

The reliability of this research is assessed by means of what Kirk and Miller (1986:41-42) call "syncronitic reliability" where qualitative analysis measures "similar observations within the same time period" and where it is understood that such observations are "rarely identical." For example, the words used by different research participants, or the data collected within different time frames, are seldom, if ever, the same yet they can be thematically and conceptually consistent. Rather, it is that the understandings people bring to their lives and contextually embedded meaning has changed over time, not that the methods of data collection and analysis are unreliable. Finally, we bolstered both reliability and validity by keeping systematic field notes and analytic memos (Corbin and Strauss 1990, Silverman 1998).

The intent of this research is not to achieve numerical representation of a population where the goal is to predict the behaviour of populations based on analysis of a representative sample of that population. Rather, our intent is to draw conclusions from individual experiences in order to make conceptual or theoretical generalizations (Ruddin 2006, Firestone 1993, Williams 2000, Yin 1989). In other words to generate what Williams (2000:215) refers to as “moderatum generalisations” or “generalisations about every-day life” where an informant’s individual and particular perceptions, beliefs, and experiences “can be seen to be instances of ... broader” cultural features (Williams, 2000:215) or “generic social processes” (Blumer 1969, Prus 1997: xi-xii).

3.4 Ethical Issues

This research project has been approved by the Research Ethics Board and is on file at the University of New Brunswick as UNBF REB #2010-039. All the people who took part in the face-to-face interviews and focus group meetings gave written consent for their participation in this research. In addition, all participants were informed verbally and in writing as to the nature and purpose of the project and were assured in writing that they were able to opt out of it at any time up until the publication of the final report, and that if they exercised this right, all notes, tape recordings, and transcripts pertaining to them would be destroyed. Informants were also informed verbally and in writing that they had the right to decline to answer any question(s) posed to them during the interviews. Informant confidentiality was ensured through the recruitment process where only the research team and the informant were aware of his or her participation in this project. Further, participants’ identities remain protected in the report through the use of

pseudonyms for seniors and a numbering system for social workers. Pseudonyms have the added advantage of presenting informants as people rather than data as well as ensuring confidentiality. Informants were given the option of choosing their own pseudonyms. Using a numbering system to identify the social workers that took part in the focus groups serves to distinguish them while at the same time ensuring confidentiality.

3.5 The Research Participants

24 New Brunswick seniors over 65 years of age participated in the interviews for this research. Their ages range from 65 to 94 with 13 between 80 and 94 (54%) and 9 (37.5%) between 85 and 94 years of age. The number of seniors we spoke with who fall into the older age ranges is similar to the number who receive home support (41% over 80), but much higher than the number of seniors in those age categories in the Province where only 15% are between 80 and 84 and 13 % are over the age of 85 (Mather et al. 2011, Stats Can 2006C). This is because in order to qualify for home support services and individual must need help with at least 3 activities of daily living (ADLs), something seniors in the lower age ranges are less likely to experience. Half (12) of the seniors interviewed of this research lived alone, 8 with their spouse, and 3 with family members. Of those living alone, all but one were female, reflective of the fact that all but one of the seniors we interviewed who are part of what Statistics Canada (Stats Can 2006b:268) call the “old-old” cohort of seniors (those aged 85 and over) are women and are thus more likely to live alone.

4 men and 20 women took part in the interviews (77% women). While this is reflective of the number of women who receive home support in New Brunswick (77%), it is slightly higher than the gender distribution among seniors in New Brunswick in general (Mather et al. 2011). This reflects the fact women account for 70% of seniors over 85 years of age in Canada (Stats Can 2006d). 20 of the 24 seniors we spoke to were or had been married and just over half (11) were widowed. The women we spoke to were more likely to be widowed than the men (58% vs 24%), again reflecting the longer life expectancies of women than men (Clarke 2008, van den Hoonaard 2009, 2010).

Among the seniors who took part in this research, 7 identified as Francophone and 17 as Anglophone (29% Francophone), fewer than the total number of Francophones who receive home support in the province (34%) and the same as the number of New Brunswickers who claim French as the language they speak most often in the home (Mather et al. 2011, 29%, Stats Can 2011a). Of interest, we spoke with more than one senior who identified as Francophone but who opted to be interviewed in English and two informants identified as Francophone but spoke English better than they did French.

Slightly more than half of seniors in New Brunswick (52%) have not completed secondary school (SD/DS 2008). Slightly more, 58% (14) of the seniors who took part in the interviews for this research told us they had only some grade school level education (the highest grade 10). The work histories of the seniors we spoke to varied but almost half had low waged jobs in sales and service or worked in low skilled and low waged trades (Stats Can 2006e, 2011d). Thus, it was not surprising that almost all the seniors

we spoke with lived on low incomes consistent with the median income of $17,938 reported for seniors in the province and the $1405 median monthly net income of those who receive home support in New Brunswick (Mather et al. 2011, Human Resources 2011).

13 of the 24 seniors who participated in the research told us they still drive, commensurate with the 50% of Canadian seniors driving in 1996 (Bess 1999:2), but a smaller proportion than the 71% of Canadian seniors over the age of 65 in 2006 who “had a valid driver's license and access to a car” (Turcotte 2006:43). This is likely reflective of the lower incomes found in Atlantic Canada and the fact that only 3% of Atlantic seniors had access to a vehicle in 2006 (Turcotte 2006). 75% of the male informants who took part in our research told us they drive in contrast to 50% of the women over 65 we spoke with, similar to the age distribution of drivers across Canada (Turcotte (2006:43).

In total we recruited 11 social workers involved in the assessment and case management of home support for seniors, as well as those working in crisis intervention for seniors living at home to participate in the focus group meetings. 10 were women, reflective of gender segregation in the profession of social work “where most social workers are women” (Olson 1994:13). Of the 11 social workers we recruited, only 4 were Francophone, far fewer than the 56.5% of social workers in the province who “use French at least regularly at work in New Brunswick” (Stats Can 2011c). The French speaking social workers we recruited work in Northern regions of the province where “77.4% of the population has French as its first official language” and almost all (96.5%) social workers speak “French at work” (96.5%, Stats Can 2011c).

4. Successful Daily Life

In many respects successful daily life is no different for those over 65 years of age than it is for those under 65. We all need to feed and clothe ourselves, keep our houses clean, and deal with shopping and other daily tasks. Notwithstanding the universality of the activities and tasks associated with successful daily life however, how we accomplish them can change as we age. In talking with the seniors and social workers who took part in this research we found that seniors are able to accomplish the activities crucial to successful daily life when they are able to weave together the systems of formal and informal support so essential to seniors “aging in place" (Gardner 2011:268).

The seniors we spoke to said that they need to get out to buy groceries and do their banking; go to the doctor and pick up medication; as well as to attend church and visit friends or family. They need to deal with snow removal, house repairs in addition to housecleaning, seasonal and on-going tasks that loom large in the lives of many seniors (Weeks and Leblanc 2010). In achieving all of the tasks associated with successful daily life, these seniors relied on informal networks of support made up principally of family and friends, and formal support networks; the mainstay of which are home support services.

4.1 Informal Support Networks

The seniors we spoke with rely on the assistance of spouses, children, friends or neighbours to do the things not covered by their home support services. Thus, a strong

informal support network means that seniors can get groceries and medication, have their driveways ploughed, or maintain a garden. For instance, for a number of years, Beverly, relied on her husband to buy the groceries as her illness prevented her from completing that task: “He did all the groceries. Well … we were very fortunate. He had been retired for nine years.” Many seniors we spoke with could also call on one or more children to help them in various ways. For example, when we asked Pearl how she gets her groceries and medications she said: “Well my son and his wife and then my daughter, so I'm quite well looked after.” Angela told us: “I don't think you appreciate your kids 'til you get to the point you really need them. I don't know what I would have done without them, honestly.” However, many children have families to care for and full-time jobs and while they do the best they can, they may not always be available. As Joan explained to us, relying on children means a dance of mutual accommodation. In her words:

> Our son-in-law will do things if I call on him, you know, but he's so [busy] … and he has a lot of meetings and … he teaches some courses as well, so he's got papers to mark and exams to set and all that kind of stuff. So he's a very busy man, so we try not to add to his burden, but if he happens to be here, you know, we'd just say: ‘by the way, can you take five minutes to change the light bulb’ and … he's glad to do it…. (Joan)

In addition to the support of their children, some of the seniors who took part in this research could also count on friends or neighbours to help them. For instance, Linda told us: ‘there’s two tenants that helps me a lot…. They say: ‘don’t worry about shovelling, cleaning your car or anything like that’ and Florence said: “I have two neighbours who watch to see that I come and go properly.”

In contrast, the social workers we spoke with saw cases where seniors could not rely on family to support them. For example, one social worker we spoke with told us: “That is something … in rural areas that is being done less and less, families being involved, families giving more support” (SW1, FG A). Likewise, several seniors who took part in this research told us that their children did not live locally or worked full-time and could not provide them with practical everyday support. According to Madeline:

> I don't want to bother the children too much. If we were stuck, [my son’s] the one who would come, he's the closest…. The others are out in the country, farther away. It takes my daughter half an hour to get to [here]…. they work during the day, what can you do?

The relative lack of employment opportunities in rural parts of New Brunswick means that children often have to move away to find a job. According to Loretta:

> 'Cause there is lots of seniors and going to be, you know, like, especially in this area, because there's really not much work, so there's not a lot of younger people, you know, it's just, and I find a lot of them are, that they moved away. (Loretta)

The outmigration of youth means that it can be a matter of luck whether or not children are there as Angela pointed out: “I'm lucky. Both my kids live here. I really am.”

In addition, more than one of the seniors we spoke with told us that their friends had all died or that their neighbours had moved away. For example, Carol told us:

> I did have a neighbour here, up until three weeks ago, and they've moved to a senior’s home…. And [she] liked to shovel and she did my balcony and, 'cause she liked, she … just turned 74, but her husband was a very bad diabetic and he needs the care.

Even among those who still had neighbours and friends, some were reluctant to ask them for help, particularly where personal care is concerned. According to Beverley:

> I know some people who require personal care do have maybe a friend or two, you know, if you happen to be out late or something, who'd make sure you got to bed. But I've just never gone there…. that would be outside of the bounds of friendship kinds of relationships.

4.2 Formal Support Networks

Clearly, informal support networks are crucial to successful daily life for seniors however, formal support networks are also key to enabling them to remain in their own homes (Shiner et al. 2010). Indeed, home support services are often the most important part of those networks and are as important, if not more important than medical services, in enabling seniors to remain independent (CHCA 2008b, Crowell et al. 1996, Gunnarsson 2009, HCC 2008, Hollander and Prince 2007, McCann et al. 2005, Nugent 2004, Sanders et al 2005, Sarma et al. 2009, Wilkins and Beaudet 2000). Moreover, home support is less costly than nursing home care for seniors without serious illness or disability (CHA 2009; Chappell et al. 2004; CIHI 2007; Forbes and Janzen 2004; Hollander and Chappell 2002; Hollander et al. 2007, 2009a; Shapiro and Havens 2000; VON 2008, Wilkins and Beaudet 2000). An insight not lost on the seniors we spoke with who said:

> And it's still, by staying home, it's still less than staying in a hospital.... Because I've spent a lot of time in the hospital and I know what it costs the government to keep you there. (Florence)

> So I guess they weigh the difference between me going into a nursing home, what it would cost, and help me look after the house. (David)

> Now she's on a list to go in an old people's home and it cost us very little to keep her here. And the old peoples' home there's about 5, 600 waiting to get into different ones and you have to wait "til somebody dies. And it's more expensive for the government to keep a person in old people's home. (Benny)

All the seniors who took part in the interviews were, in general, happy with the home support services they receive. For instance, Angela told us: “You couldn't ask for more, really.... I think we in New Brunswick are really fortunate." Others said things like:

> We're pretty pleased with what she gets now … [it] seems to work out good.… Mom does stay alone when my brother's not here. Now if my husband's away, I usually stay. But she does stay alone so it's just nice to know that somebody is coming in here at nine o'clock in the morning. (Sally)

> Everything was just wonderful, such a help.... Because she looked after, when I had someone, they looked after giving me my pills, and.... I always thought it was wonderful, a wonderful service. (Florence)

> The services really come in together.... I can sum it up this way. If I was living in United States and … under the same circumstances that we have here ... I wouldn't be sitting here talking to you today. I know it for a fact. No. I'm very, very grateful for the help I am getting. (Ernest)

> And I'm very grateful that we have what we have.… Very grateful for all the services, for everyone that's been involved in the services because it takes many people to bring it all together and we're really very grateful….I just can't complain. (Monica)

4.2.1 Home Support Workers

The long term care program has a variety of services that can be offered to seniors, however, the form home support takes for 89% of seniors in New Brunswick is house keeping or homemaking services (Mather et al. 2011). All of the seniors that we spoke with who are currently receiving home support had homemakers or personal care workers who were locally based and almost all seniors who took part in this research were very happy with their home makers. In fact, many of the seniors who took part in the interviews told us that they couldn’t do without them. Madeline put it this way:

> I've known [my homemaker] for a long time. If you send me someone else, I'll be lost. It's a nuisance because I'd have to show her where everything is and what I want done and see if she's doing it right.

The seniors we spoke with described a ‘good’ homemaker as someone who knows exactly what needs to be done without being told (Aronson 2003). For instance Pearl said: “She'd just go ahead, you know, never had to tell her anything” and Toni told us: “I got [my current homemaker].... and she' excellent…She just comes in and does her thing.” Madeline explained that a good homemaker is one who has had some sort of training in how to keep house. She said:

> I had … a young girl who was smart, no more than 25 years old, her grandmother had taught her how to work. So when they’ve learned beforehand, they can do it. You know, it’s not everyone, eh?

The seniors we spoke with also told us that good homemakers and home support workers were ones that they could establish a relationship with. The relationship between a person and his or her home support worker is as important to successful daily life as are the particular skills that worker has and the emotional care provided by workers, as well as the quality of the relationship between workers and clients, both contribute to senior’s satisfaction with home care (Edebalk et al.1995; Francis and Netten 2004; Gantert et al. 2008; McWilliam et al. 2001, 2003; Piercy and Woolley 1999). For many seniors, skills and knowledge do not necessarily refer to professional training, rather seniors want a worker who is motivated, has good communication skills, and has had personal experience providing home support (Francis and Netten 2004). The seniors we spoke with valued having a personal relationship with their home support workers. In David’s words: “I've gotten to know her and her family and it's quite nice. When we asked Toni what makes a good homemaker, she told us personality mattered. She said: “They've all had a good personality, all the ones I've had. I've never

had … trouble with any of them." When we asked her to explain what a good personality means she said:

> Well when she comes in, she says: 'good morning, how are you?' Cheerful, yeah, and 'what did you do on the weekend?' and that. And then she tells me what she did. And on Wednesday, she brings me a muffin and coffee. From Tim Horton's, and she has her lunch then because she comes in from Lincoln. And then she leaves me a snack for supper there, a wrap for supper every Wednesday night.

In contrast, problematic homemakers were those who need to be told what to do. As Toni put it: "Certain people can do this job, not everybody, believe me..... Last summer I had … nursing students, two of them, and they weren't bad, but you had to tell them everything." In particular, these seniors told us that they not only had to tell their homemakers what to clean, but also how to clean. According to Linda and Maxie:

> I had one, I had to get rid of her … she wasn't doing [the work], well, first time she came she was going home, I said: 'Aren't you going to wash the floor?' She looked at me, she said: 'It's not dirty.' So, another time I told her take care of the counter, you know, clean that up and she pushed things around, and it wasn't really cleaning at all. (Linda)

> They just half do things. There's too many young people…. I had one ... never dusted.... You know because they never did [what they were supposed to do], I've got a list on the fridge of what they do, but they never, ever looked at it…. and some of them say: "Well, I just can't cook.' What are you sending them here for if they can't cook? … Some of them didn't know how to use a vacuum cleaner, let alone cook. (Maxie)

Other informants told us that the some homemakers sent by agencies behaved unprofessionally by not wearing a uniform or nametag; smoking, and/or being unreliable. In their words:

> They sent me young girls not dressed, in pyjamas, no top, and things like that. And it doesn't look like they work for [a home care Agency] but for themselves…. [My homemaker] always comes with her top and her nametag…. it has to be like that. (Madeline)

> The ones that smoke, I can't.... The last time I was.... laid up for a day after.... and it isn't that they smoke in the house, it's that it comes in on their hair and their clothes (Jessica)

> And some day they say well, my husband needs the car tomorrow and I won't be able to come or something like that. (Genvieve)

The level of skills training of home support workers was of particular importance for the two informants who needed personal care. According to Beverley:

> About two years [ago] I had to use a catheter; it's still a permanent thing. And so that's another issue. You know, to me, that's something that I would get very nervous to have someone who doesn't have any personal care training or experience even to be doing that. And still, like some of the girls who might come in, you know, tonight there'll be one. I was just thinking today, oh yeah I think she did it once and … once they have and I know they understand it. But as a rule, there's like two different types of workers, but you get them no matter what now….. There are, but they have different duties.

Likewise Joan said:

> I think that, on the basis of some of the homecare workers that we had in home or around the house from Red Cross, some, I think they're supposed to be trained, you know, to do some personal care, but so far it hasn't seemed compatible…. or comfortable. I guess, comfortable, that's the word we want. I think, you know, LPNs or RNs, who are used to this sort of thing, if we could get more of them, but that's the, sort of the ultimate desire, like utopia that we would like to see. (Joan)

4.2.2 A Lack of Continuity

Another issue that the seniors we spoke found difficult is the frequency with which homemakers change. According to Madeline: "they sent me all kinds of women then I said: 'Listen, I'm getting really tired of all this, having to say: 'go do this, go do that.' I can't do it anymore, I can't breathe anymore!" Such discontinuity of care is particularly problematic in the case of personal care as the following seniors told us:

> Well I expect [her] for private stuff…. So she was away here about a month ago.… So I went without my shower then…. I had six homemakers all together…. And one girl I have three times a week, except the weekend, she's off…. You have to tell them everything all over again. (Sally)

> Mom doesn't like when the homemaker that gives her, her shower. If she's not going to be here Mom doesn't [have a shower] 'cause you get used to one person. (Sally's daughter)

4.2.3 Home Support Worker Rules

Several of the seniors we spoke with told us that their needs went unmet because of agency rules that govern what home support workers can and cannot do. They said things like:

> Gloria's never refused me, but another one I didn't know from [the other agency] would say: "I'm not supposed to do that'…. They have rules (Madeline)

For some this meant housework seniors thought important would not get done. In their words:

> There are limitations, yeah. They can't climb ladders in your home. For instance, they can't do that sort of thing like if you want them to clean on top of the kitchen cabinets … you know how grimy that can get..... They're not obliged to do that. (Joan)

> I need curtains done badly, but [my homemaker] can't do them under the terms of her work. (Carol)

> Yeah. [laughter]. Like the one I have now, I asked her to, well I wanted to scrub the floor, you know, because, and then wax it, things like that. So I said: 'Would you mind?' I said: 'I would help you.' She said: 'Oh no, that's hard cleaning, we're not allowed to do that.' (Linda)

For others it meant activities that prevent isolation and promote stimulation don't happen. For example, Emilie, who uses a wheelchair, lives in a very isolated situation. While she would like to go to the senior's centre, she is unable to in winter because she

cannot use her motorized wheelchair in the snow. Using her manual wheel chair means she needs assistance to open doors and negotiate transportation. She said:

> I go … sometimes to Stepping Stone, but if there [is] too much snow you bring all the snow with your wheel and everything. I have a manual wheelchair but a homemaker came with me at first with my manual wheelchair and my gosh she said: “the homemakers are not paid to go to Stepping Stone.” (Emilie)

Similarly Sally’s daughter told us that homemakers aren’t supposed to play cards with her mother, a form of stimulation and entertainment important to Sally’s daily life. In her words:

> But I'll tell you one time the [agency supervisor] come in and he caught us playing and she lost. And they took her away…. They said you shouldn't be playing cards. Well you know, like I would say they're just to do things with their client really, so as long as Mom's happy with what they've done.... they're allowed to do things on this list…. And it doesn't seem to be really be oriented around, like say if … the elderly person couldn't read or couldn't see, if they wanted to read them the newspaper, they should be allowed to do that. Now Mom's … doesn't have that problem. But some of them probably do. (Sally’s daughter)

Rules also govern how many and what hours home support workers work which can result in unmet needs. For instance, Joan told us that her husband Paul who has mobility problems, needs help getting in and out of bed, something she is no longer able to help him with. In her words:

> Well I guess one thing that really concerns me is that we don't have, in this community, we don't have enough home support like for home care after hours. It's kind of a nine-to-five thing and with people like Paul, here, who has Parkinson's, we sometimes could use help. Getting up in the morning, going to bed at night and maybe sometimes even having someone overnight and the other thing, the flip side of that coin is we need more male home support workers, there’s very few men in the, you know, who are, who might need it. (Joan)

4.3 Technology

Another part of the formal support the seniors we spoke with depend on is technology. While very few had computers or used the Internet, many banked by phone and used other types of technology. For example, Maxie and Ernest had monitoring systems set up in their homes.

> There's [a monitoring machine] I have…. it's through social development…. it's the most wonderful thing that ever happened to me…. because see I've got cameras all through my house except in the bedroom and the bathroom, they're just sensors, so they can tell when I'm out of my room or whatever. I have them on my doors…. if I go out and don't come back. (Maxie)

> It's right in the corner and ... it's just a matter of if it's connected. (Monica)

> And regardless of where I am in the house. (Ernest)

> He can hear it. They can hear him. (Monica, Ernest's wife)

> They can hear me. (Ernest)

> And if they can't hear him, they just call ... call for help (Monica, Ernest's wife)

Almost all other seniors who participated in this research used some form of Lifeline monitoring systems, either in pendant or wristband formats. Some of these seniors told us they were very satisfied with Lifeline. For instance, Beverley told us: "I wear it all the time. When I first got home from the hospital, it saved me" and Florence said:

> Oh, that's a wonderful thing because I'm alone.... And I always, I always had the fear that I might fall down the cellar steps and nobody would miss me because I don't have people coming in every day. (Florence)

However, some of the seniors we spoke to told us that they didn't wear the Lifeline wristband or pendant regularly, particularly at night because it was too easy to set it off by accident. In their words:

> Oh, lots of times. I'd turn over in the night…. Well they just … If I turn over and I push it by mistake, they just ring their bell and say, are you alright? And I'll say, now why did you call? (Florence)

> So, they're saying we're going to send an ambulance and I come in the room and say, why are you sending an ambulance? Well, I guess it, Anyway they phoned us back from the hospital and said, they're getting a garbled message on your machine, do you need an ambulance? And I said no, we're fine…. It's just, It wasn't then the girl came in and said that our phone was setting it off. She was going to bring a new one if it came, kept up, but we haven't had any problems since. (Jessica)

> So he talked me into buying this, but one, three different times, shortly after I got it, three different times, that sound. You know, there's a sound to it. And once was, I was in bed and it, sleeping, and it woke me up and I got mad and I phoned the company and I was wanted them to take it out, but I had signed a contract…. It would just [go off], I was nowhere near it. I was in the other room. One time I was in bed and I said, I'm not anywhere near it. How come it's going off? (Angela)

Others found the device irritating to wear. According to Yvette: “I had the Lifeline… I let go my Lifeline because I have sensitive skin and it was making my skin [sore].” Those who didn’t use Lifeline at all told us: “I don’t think that I need it” (Genvieve). They said things like:

> No, I don't... I certainly have fallen a lot with the balance thing, but I'm more cautious now and I don't do anything if I can't hang on, at least with one hand. [I] don't need it.... I mean if I fall, I suppose I would have done the same thing maybe, I don't know. (Rosie)

> They wanted to give me one 11 years ago, but I said we aren't far from the hospital….I could maybe have one, I don't know…. I have [a phone] in my bedroom. If something happens, it's not far to my bedroom (Madeline).

When we asked them to explain why they didn’t think they needed it, they said:

> I don't believe in that 'cause I know some people that, you know, had that, but they still died. They still had problems. (Genvieve)

> And besides, most people that I know have a Lifeline, fall down and break a leg [laughing] So why pay $35.00 a month? (Yvette)

Others explained that they didn't use Lifeline because the cost was prohibitive given their limited incomes. In Emilie's words: "I have to pay for this, $23.00 dollar a month.... Yeah. I don't know if I'm going to keep it.... I probably couldn't afford [it].

4.4 Poverty

A structural factor that mitigates against a senior's ability to coordinate informal and formal networks of support is his or her income and low income seniors are more dependent on home support and home care services than seniors with access to more financial resources (Alcock 2002, Angus et al, 2005, Baker et al 2007, Davin et al 2009, Goldberg 2010, Keigher 1999, Plouffe 2003, Raina and Wong 2002, Raina et al 2000, Raphael 2007, Veall 2008, Veenstra 2000). Poverty rates for seniors have declined since the 1970, due in part to the introduction of the Guaranteed Income Supplement (Leacy 1983, Senate 2009, Veall 2008, Yalnizyan 2010), however, according to Raphael (2007), in 2004, 17.8% of women over 65 and 9.3% of men in Canada still fall below the low-income cut off. Moreover, research on Atlantic Canada shows that the income levels of seniors living in this part of the country are lower than the national average (Shiner et al. 2010), thus poverty remains a problem for seniors in New Brunswick where, according to the New Brunswick Council on the Status of Women, almost 7% of people over the age of 65 live in poverty (NBACSW, 2008). Over half (52%) of seniors who receive home support in New Brunswick have incomes so low that they receive the Guaranteed Income Supplement (Mather et al 2011). They said things like:

> I mean people only think, well, you're a senior, you have money. I don't have nothing. And all I live off is $1,348 a month. And I never have nothing coming in. I have nothing else. (Maxie)

> Unless you can raise my pension.... You know I don't see, I don't see how they expect us to live in the same way that a person who works does. They have salary coming, and we don't. We only have a cheque once a month. And we don't, we don't make as much as the person who's working. (Linda)

> Well, the only thing that concerns me right now is that, if I get sicker, will I have help from the government because we pay $800 in rent, and we pay for the phone and TV, but we have medications. I need personal things, and we always need things, we need to pay for groceries, of course we need groceries. My bread because you tell me you won't eat much of it. You make a sandwich every once and awhile and things like that because you can't spend all your money from your cheque since it goes there. (Madeline)

Many of the seniors who took part in this research told us how they had difficulty meeting their expenses and in particular had trouble with the costs of food, pharmaceutical products, and medical supplies. In their words:

> Knights of Columbus. Oh yeah they have the Meals on Wheels, but it costs me more than paying the homemaker's to make it… I think it was around 6, 7 dollars something like that…. But I think [we should be] given a discount on the food, especially food.... [Linda]

> Well they have that at the drug store, don't they? Tuesday is the senior day or something? (Linda's Son)

> No, they don't have that anymore.... And the pharmacy, you buy something it's a certain price at one pharmacy, you go to another one and it's different.... Same thing with the milk. You go to the pharmacy you pay 3.50, 3.19 for a 2 litre of milk. You go to the co-op, 3.60. [Linda]

> I have to buy, my socks cost so much, $8 $10 a pair... They are diabetic and comfort socks. So I sleep with my socks all the time and shoes [are] terribly expensive…. Each one I pay almost two thousand dollars…. I [need them to] never again have more problems with my leg all swelled up. They were made all the way up in Alberta or Vancouver, I don't know where, that far. Anyway the boots, they have to make a special boot too. Before they were free when I was on Social Services and now it's the Blue Cross [who] pay [part]. That last pair I had done was eight hundred something…. I pay about four hundred something for the shoes. I pay a little bit more now. Before they

> didn't want to pay for them. They said the arch support are made with the shoes. I said no, they come out. I had to stay there and fight with them until they give me a little bit, not much. And you had to have letters and letters and letters, drawing of the foot and everything…. I'll have to do what I can do with the income I have. I'll have to be careful, so. Like I said, you have to send the blood, $5 or $6 to send the blood, and you have to buy the Heperin…. $1000 for two little tubes. (Emilie)

> I got my glasses in November, and I had to ask them if…. I could pay … so much a month. Well, I'm going to pay next week, it'll be finished then. And they allowed me to, because I didn't have the money to pay for them. (Maxie)

> Well, I have one, two, three, four, five. Five [medications I think.... One costs $3,000 a month....The doctor gave me a prescription, I went to see him. I went to the pharmacy and gave in my prescription. The girl came and said that one of them wasn't covered. The doctor said there had been a switch. I didn't think right away, but a switch takes 15 days, 10 to 15 days. I asked how much it cost. She said it cost a lot: $1,000 a month.... and there, I get ... what's it called? Once I have reach $200 worth of medication, I don't pay any more.... Like I said, it's the only one that's not covered. The $1000, I don't know what will happen with that. I'll call him in two weeks to find out what's going on…. A thousand dollars a month more, I don't know what it is. If it doesn't agree with me, I'll tell him. I don't want it. (Madeline)

> Since I don't smoke and I don't drink I'll take a bottle of beer now and then, but I save money that way. I like concerts and there's a good concert coming up Wednesday evening…. I'd like to go to that. This one I think I'll be able to afford it because it's a voluntary contribution. It's a fundraising deal. So that I can go to. But there is one I would love to have gone to … a beautiful violinist. I've heard about him. I used to play myself, but I can't play any more, but I still love it, but I couldn't afford it…. It was $30. So when something like that, I think, well maybe I can afford a CD and can listen to it any time I want to, but it's not like going to a concert. (David)

In addition, several of the seniors we interviewed told us they struggle to make ends meet and that while the client contribution they pay for home support may seem small to others, it represents a significant sum for them in their monthly budgets. In Rosie's words:

> I pay my, for a month I think it's $82.33 or something…. And then whatever they pay, I don't now it must be quite a bit… [but] we pay a lot, we'll be paying $650 for our rent and then you" add the co-payment. (Rosie)

4.5 Discussion

As discussed above, successful daily life for seniors requires that they weave together formal and informal networks of support. In turn, a senior's ability to coordinate these systems of support varies by the robustness of their informal and formal support systems, in addition to the type of housing they live in, and their access to appropriate transportation. Finally, their need for robust systems of formal support, the lynch pin of which are home support services, is exacerbated by their limited incomes. In addition, the quality of their formal support networks is compromised by a lack of continuity of care when home support workers are frequently changed and by what seniors feel are excessive rules controlling what services home support workers can provide.

5. Transportation

Not surprising, given the bulk of research on aging in place, is that access to transportation was a topic that was raised over and over by the seniors we interviewed. The literature on independent living for seniors shows that seniors persistently identify transportation as among their most important needs (Chernesky and Gutheil 2008). Moreover, transportation is crucial to their "quality of life,… contributing substantially … to their level of independence" and sense of personal autonomy (Farquhar 1995, Rudman et al. 2006, Shope 2003, Smith and Sylvestre 2001, Turcotte 2006:43). According to Genvieve, one of the seniors we spoke with:

> I'm not that bad. I do my own work and I don't need anybody ... I drive…. as long as I can walk, I can use my car. As long as I have a car, I'll be doing my own stuff, I guess…. I do my own thing and like I say, as long as I have my car to drive I can go anywhere at all.

5.1 Driving

Just over half (13) of the seniors who took part in this research told us they still drive. Most of these informants (10) were under 85 years old, slightly less than what is found across Canada where "53% had access to a household vehicle, with or without a driver's licence" (Turcotte 2006:44). Proportionately fewer of the female than male seniors we spoke with told us that they drive, consistent with the current norm in Canada (Turcotte 2006). However, as Turcotte (2006) points out, the gender difference in driving is likely to disappear as future generations of women drivers age.

These seniors who still drive told us that driving allows them to go out to get groceries and medications; go to medical appointments, and to visit friends without having to rely on others. In Florence's words:

> I can drive the car … I park it outside the grocery store, and I go into the grocery store and Jean Coutu's, I get my drugs, my prescriptions there and then I go two doors up to the bank.

When we asked Florence if she was able to visit her friends she said: I don't do that nearly as much … [Laughing]. I visit on the phone….But I can visit because I have a car." Likewise, Toni told us she that because she still drives she can "go to the mall and sit at Tim Hortons with all my friends." Moreover, driving was not only seen by these informants as useful in accomplishing the tasks that are necessary to successful daily life, it was seen as essential. According to Linda:

> Before I had my eye operated on I had a hard time to, I had to be careful. And then this one specialist, he wanted to take my license off [me] … so I said: 'you're kidding,' said: 'no' and then I went to see my Optometrist, she said: 'No, … they're not going to take your license … no, no." So anyway … I kept my license….. [Without it] I wouldn't get my groceries, I couldn't drive to the church, go to the pharmacy. (Linda)

As essential as driving is to these informants, they were careful about when they drove. For example, Genvieve, and Linda, told us that they do not like to drive in winter. In their words:

> I went to Moncton last, it was September, I think, but then winter time, I don't want to take chances, especially in winter, like this winter, eh? So much snow. (Genvieve)

> I know my limit.... In the winter during storms if there's a lot of snow, or the roads are icy or something like that you know, I hate driving in the icy roads. (Linda)

Even when they themselves could no longer drive, some of these informants still had access to a vehicle that family members would drive for them, something quite common among seniors across Canada (Turcotte 2006). According to Joan:

> Yes I drive, but I haven't been driving … since just after New Year's because I don't trust myself with the vertigo.… [our son and daughter-in-law] have our car …. They're using it as a second car but they will tote us around. [My daughter-in-law] will make time for appointments…. and I try to make them on the days when she doesn't have her courses… I won't ask her to skip a course and I don't think she … would want to either. So we try to accommodate each other that way.

Some even had friends they could rely on to drive them to where they needed to go, even if they were reluctant to ask them to do so. For example, Florence told us:

> I don't want to ask friends and neighbours. One time, I have [neighbours] who live two doors from here. And they're both retired teachers and they always say: 'now if there's any place you want to go anything you want to do, don't hesitate to ask.' I've asked them once … and that was to go to the airport. And they took me and I paid them some. They didn't want to take anything, but I put it in the car. But it was a way to get there.

Furthermore, a few of the seniors we spoke with who could not drive themselves said that their homemakers would drive them to medical appointments or to go grocery shopping. For example, Angela told us that her homemaker took her to the doctor. She said: "Oh, the last time I went to my doctor, [my homemaker], the client she had in the morning, she traded [so] she came with me in the morning." Similarly, Emilie told us her homemaker used to provide her with transportation. In her words: "Well my homemaker.... I used to go with her all the time, but she changed [her] car, [she's] got a van now, [I] can't get in it…. She's supposed to take me shopping" (Emilie). However, the social workers who took part in the focus groups told us they were not "supposed to have … the homemakers doing it [driving]" (SW9, FG B). Moreover, Maxie told us that

only homemakers with special insurance are allowed to drive clients in their cars: “You ha[ve] to be insured if you want to take your patient to the doctor or grocery shopping or things like that” (Maxie). The seniors we spoke to said such insurance certification was a rarity due to cost. They said things like:

> You see the girl has to pay for the license to transport the handicap. You have to pay more [for that license] so they don’t take it. (Emilie)
>
> The main thing is you have to have $2 million worth of insurance otherwise you're taking a chance. (Monica)

5.2 Accessible Transit

Saint John is the only municipality in New Brunswick to provide accessible transportation through their public transit system (PCSDP 2011). A patchwork of 21 different, for profit and non-profit, companies and service organizations provide accessible transportation for seniors and people with mobility impairment in other, but not all, parts of the province (PCSDP 2011). For example, Emile told us that her church used to organize transportation for parishioners. In her words: “Yeah and the church they used to have a taxi, to go to [church}, they used to have something to take a wheelchair.” In contrast Sally told us there was: “nothing like that here.” Likewise, Linda had no access to accessible transportation where she lived, something that surprised her son. In their words:

> Don’t they have a shuttle bus around here? They used to it seems to me….The Lions Club used to have something there that if that did happen they’d bring you to go get your groceries and stuff like that. (Linda’s Son)
>
> Here? (Linda)

> Yeah, seems to me they had that years ago…. If you had to go to the drugstore, or the Co-op, or doctor you'd call up the Lions and you'd get on the list and you'd say you have an appointment such and such a time or you'd like to have a ride. (Linda's Son)
>
> I never heard of that. (Linda)

Likewise, one of the social workers who took part in this research told us there are parts of the province where there is no wheelchair accessible transit. She said:

> In Caraquet, they need two wheelchairs if they want to function in society because they can't have an electric wheelchair and take transportation. There is no transportation, vans adapted for them. So they need a manual wheelchair if they want to go to their brother's or sister's or go to the mall. Every year, when I had a caseload, I fought with the Province, saying, listen here: they have the right to go out, even if there's snow. They have the right to go out and the right to go see their doctor. So they need two wheelchairs. It's not a luxury. (SW4, FG A)

According to the Premier's Council on the Status of Disabled People, publically funded forms of accessible transportation (Dail-a-Bus, Ability Transit, etc), are also "typically under resourced" (PCSDP 2011:i), as one senior told us:

> Well right now it's hurting a little bit because we're a little, [we're] not keeping up with the demand. It's been 25 years and two years ago when we applied for municipal funding; we were declined for the first time…. you know, we've been cutting pennies in half practically…. The city's growing. It's spreading in all directions. Population's increasing. The area getting from one end to the other takes longer, you put all those factors in there, and you're not getting a person every 15 minutes anymore. (Beverly)

Also problematic is that most accessible transit programs in the province "require passengers to make reservations; often several days in advance" (PCSDP 2011). According to Emilie, it's: "very hard … to get Dial-a-Bus…. [You] have to put your name in two weeks ahead…. They need more Dial-a-Bus. (Emilie). Similarly, Beverley told us:

> I know in Halifax, you have to call within, I don't know what it is, 10 days or seven days or something. [Here] I could call this afternoon and say, do you have anything? …. People can call on the same day and If there's something

> available, okay. There's not likely to be because when the morning would have started, every space would have been filled, but every now and then I'll hear, actually, somebody just cancelled. Your timing was [perfect]…. I don't quite understand. It must be their booking system that needs a little bit of Planning ahead of time in Halifax because I'm going for Christmas and now my drive to go where my brother lives…. Well, it's a fair drive from there to the train station…. I said rather than have somebody drive me there, I'll just take the bus and go. So he said, well for that one, I'll have to wait and book on the 20th I think it is, so they're still doing that. (Beverly)

In addition, Fredericton's two Dail-a-Buses, only run "during daytime hours" and on week days. In addition, "customers must be pre-approved from a list of registered users," and the service "only operates within city limits because it's taxpayer funded" (McLaughlin 2009). Moreover, publically funded accessible transportation prioritizes "medical appointments" such as trips to the doctor, over other activities that are likewise important to the health and wellbeing of seniors including shopping and socializing (McLaughlin 2009). For example, when we asked Emilie if she ever used Dail-a-Bus she told us she used it to go to a seniors' centre and that she wished she could use Dail-a-Bus for other activities that would keep her from being so isolated. In her words:

> I go to the doctor, the dentist…. If they had more Dial-a-Bus then you could get the Dial-a-Bus and go to Brookside [Mall]. Things like that…. There are people who take the [city] bus every day. They go to Brookside, they want to go all the time. I cannot go on the [city] bus. (Emilie)

5.3 Taxis

Most of the seniors we spoke to did not use accessible transit either because they still could drive or had access to a vehicle, or because there was no accessible transit available in their area. In most of these cases the seniors we spoke to relied on family members and in some cases homemakers to get them where they needed to go. For example, when we asked Angela if she used accessible transport, she replied "No,

usually, one of the kids will take me in the car." A few of these seniors also used regular taxis. For instance, when we asked Rosie how she got to the grocery store, by using the Venture Van or calling a cab she said: "I'd call a cab…. They do have a [the Venture Van] trip to Sobey's at 9:30 sometimes on what, Tuesday mornings? And I used to do that when I first came here. I don't do it now." Thus for some seniors, taking regular taxies is a viable option to meet their transportation needs. For instance, while she needs to "make the most" out of each taxi trip, Rosie can afford the occasional taxi fare. In her words:

> I don't go anywhere unless it's in the mall…. the taxi fare back and forth, you know, and then I'll try and make the most of it…. Well they're reasonable, I think, $6 or $7 to the mall and then … the same to come back. (Rosie)

However, taxi fare is beyond the financial means of other seniors we spoke with. According to Emilie: "Taxis are expensive…. I could never afford that."

While transportation is nominally an item on the menu of home support services in New Brunswick, the social workers who took part in the focus groups told us that it is something they are rarely allowed to approve for their clients.

> We're discouraged from putting transportation down in any way, shape, or form …we can't even approve a taxi once a week…. (SW 6, FG B).

> See, we do that…. (SW9, FGB)

> 3 hours a month? Or, what's the menu, 4 hours a month? (SW8, FGB)

> I don't know…. We are so discouraged from doing it that I don't even know what it is…. (SW5, FGB)

> [Only] 3 or 4 hours a month to be able to take somebody out to get their medications, to get their shopping. (SW8, FGB)

A recent addition to the taxis available for seniors in Fredericton is Brunswick Accessible Taxi's BAT Mobile, a specialized taxi service that can accommodate wheelchairs. The BAT Mobile was not a service used by any of the seniors who took part in the interviews and was only mentioned once in the focus group discussion when one social worker said: that "the BAT Mobile will provide transportation to the doctors' visits" (SW 11, FG B). However, while the BAT Mobile solves Emilie's problem of not being able to take her mechanized wheelchair on board conventional taxis, the problem of cost not only remains, it is also exacerbated as the fares are higher. According to Mark Webster, President and Vice-President for Operations of Brunswick Accessible Taxi: "we have to charge a premium to reflect the fact that it's a more expensive vehicle and also we have loading and unloading" (McLaughlin 2009). Recently, the single BAT Mobile vehicle caught fire and was rendered inoperable, leaving Fredericton without a accessible taxi (CBC Radio 2011a, c).

In addition to the direct cost of transportation, there are others costs for seniors who use wheel chairs, even in areas serviced by accessible transit. For instance, Bea told us that without a wheelchair ramp the senior she lives with cannot make use of the Venture Van. In her words:

> Now we tried to get a ramp put on from New Brunswick Housing. Now they told us all this that she needs the Venture Van.… it's for people with wheelchairs, they charge so much a kilometre or something….. And glaucoma [treatment] …. This is a service that I must bring her out for. So that means I need a wheelchair ramp. I called the New Brunswick Housing for that. Just because Benny and her stay in the same house and she doesn't have the disability claim to the government.… their income's too much to build her a ramp, but they don't have the money. So … how does she get to these services? Because a Venture Van won't pick her up. (Bea)

5.4 Discussion

Seniors in Atlantic Canada lack adequate access to transportation (Shiner et al. 2010). A lack of transportation is even more acute in rural areas (Blieszner et al. 2001-2002, Forbes and Edge 2009, Forbes and Janzen 2004, Hollander and Prince 2007, Kenney 1993, McCann et al. 2005, Skinner et al 2009, Schoenberg and Coward 1998, Thompson and Postle 2007, VON, 2008), where 38% of New Brunswick seniors who receive home support reside (Mather et al. 2011). Seniors living in rural regions are "more likely to have a driver's licence, but also to have limited access to transportation" (Bess 1999, Turcotte 2006:48). Further, people who live alone are particularly affected by limited access to transportation" and 57% of the seniors who receive home support in New Brunswick live alone (Turcotte 2006:49). There have been calls to improve accessible transit for seniors and people with mobility issues such as the City of Fredericton (2010) draft master plan recommendation to "add four more Dial-a-Buses to its fleet beginning with one new minibus in 2011. While a bid has been tendered for the purchase of the new bus (OPG 2011), and an ad has been posted to hire a dispatcher (City of Fredericton 2011), gaps remain according to the social workers we spoke with who said:

> You want a little more flexibility in tailoring the plan, but you also want to add some services, like transportation (SW 6, FGB)
>
> Right (SW 5, FGB)
>
> I see that as a big problem. (SW6, FGB)
>
> Help to get groceries. (SW5, FGB)

Likewise, Florence, one of the seniors who took part in this research, saw transportation as something to be provided through home support programs. In her words: “of course it's a government expense when you have a service, but sometimes taxi service is pretty darn [expensive], If you have to pay $80 to get to Moncton and back. (Florence)

6. Housing & Living Arrangements

Seniors prefer to stay in their own home whenever possible (Eckert et al. 2004, Nugent 2004, Sanders et al. 2005, Sarma et al. 2009, SD/DS 2009b, Shiner et al. 2010). As seniors age, their immediate surroundings become more and more important (Hammer 1999, Means 1997, Rowles 1993, Swenson 1998). According to Swenson (1998:384), “home is the center of self, [and] ... the center of caring” for the seniors. Every senior we interviewed also told us they wanted to live in non-institutional settings that they could call their own. They said things like:

> Like I said, I’d feel, I’d be more comfortable, I’d be able to, if I want to work on a quilt I’d be able to do it. If I was in a home I can’t do it.... Or, anything, if I want to play cards, [I could] call my friends and [say:] ‘come on over we’ll play cards,’ you know. (Linda)

> I don't want to go to the nursing home…. As long as you have your mind, if you lose your mind then, it's different because you don't know where you are, but as long as your mind is, and Mom's is, Mom's mind is better than mine, really, she remembers things that I don't…. [You’re] just used to your own home and you can come and go and get up when you want to, go to bed when you want to and in there they just tell you what to do. (Sally’s Daughter)

> This niece I mentioned that lives only about a mile away, they would like me to go and live with them, but I like my freedom that I have. And I have company in every once in a while. A couple of Sundays ago I had company for lunch on Sunday afternoon. Next Sunday I'm going to have company for lunch. So I can do some entertaining here myself and not feel I am putting anybody else out. (David)

The seniors that took part in this research lived in a variety of types of housing offering differing levels of formal and informal support including: their original family homes; a variety of different apartments and condominiums; seniors only housing, and retirement communities; in addition to assisted living residences.

6.1 Original Family Homes

David, one of the seniors we interviewed lives in his original family home. He told us with pride about the gardens he maintains and the work he has done in rebuilding his house. In his words:

> Well I have my garden. I had a friend come this afternoon that has a truck and he went and bought some posts for me. I've got to put new posts in for the grape vine…. And just outside the door there, there's a flower garden. In that wind last week, it just blew the fence down, so I'm in the middle of fixing it. It was time for it to go anyway. The posts were rotten. So it just forced the situation. So anyway I hope I can get it done before the bad weather comes…. I built this place myself…. Well, it's not quite true. It was an old rundown place that was ready to be torn down anyway…. So I just tore it down as far as I could and then rebuilt it. It didn't have any top storey. I put the top storey up. (David)

Seniors living alone in their family homes are responsible for the needs not met by home support services such as home repairs and snow shovelling. It can be difficult for seniors to accomplish such tasks themselves or to find someone to do the repairs or snow removal for them, especially if they live alone and on a fixed income. While David, a widower, enjoys his independence and is not ready to leave the home he built for himself and his wife and has friends who will help him with his garden and fences, major house repairs are more complex to address. For instance, at the time we interviewed him, David was waiting to hear if he was eligible for funding to repair his roof. In his words:

> Well I talked to her [social worker] about the house and that there were repairs needed on the house and oh various things that needed to be done and she didn't think I was up to doing it myself. But I've done a lot and I have friends that have helped me, but right now I'm waiting for a reply from, I made application to the, Oh through the government, I forget the, social service again for some help in a few things that need doing on the house because now the roof is 22 years old. And I had one leak in it a couple of years ago and I fixed that, but any more leakage that's going to take place, it isn't just a

> matter of patching because once it starts leaking it'll ruin the insulation and the gyprock up on the ceilings. So it's cheaper to put on a new roof now than have to put on a new roof later and everything else inside. (David)

6.2 Apartments

Living in an apartment often means that seniors do not have to worry to the same degree about snow removal or maintenance and repair of their apartments. As one would expect, the seniors we spoke with who were living in apartments not only had fewer household responsibilities than those living in their own homes, but also had the added benefit of friends and neighbours in the building who would help them and look out for them. For example, most of the apartment dwelling seniors we interviewed were relieved of most snow shovelling duties and responsibility for major house repairs. They also could count on neighbours to help them on occasions as illustrated in the following excerpt of our interview with Linda.

> Yeah, there's four apartments.... we have a blower who comes and cleans the parking lot. (Linda)
>
> Is that something the landlord does? (Interviewer 1)
>
> Yeah. (Linda)
>
> He doesn't shovel. He ploughs, he cleans the parking lot, like around the car (Linda's son)
>
> Well, he lives in Shediac. Which is about 20 miles away from here (Linda)
>
> Doesn't matter where he is. But the thing is you gotta look after your own car. (Linda's son)
>
> Yeah, yeah. but (Linda)
>
> And for a while she had [the neighbour] next door, he was ploughing his car over hers. (Linda's son)

> So you would have to dig your own car out? (Interviewer 2)
>
> Yeah, but the [two] woman upstairs … there's two tenants that helps me a lot …. They say don't worry about shovelling, cleaning your car or anything like that. (Linda)

Almost all of the seniors who live in apartments or condominiums we interviewed told us they has friends or neighbours who would help them and/or check in on them to make sure they were alright. For example, Toni, who lives in an apartment building, told us:

> People in here will go if I need milk or bread.... If they're going, … I'll just phone them and ask them to get milk or bread and they get it.... [Viviane], right across the hall, she calls every day and [George] next door gets my mail every day, so they know what's goin' on.

6.3 Retirement Communities

Retirement communities vary greatly but most provide some communal services for residents such as snow removal and activity centres. The retirement communities we heard about in this research did not allow residents to own property, rather, they rented the houses that they lived in and all benefitted from some form of rent control. These communities also restricted residence to older people without small children and research shows that across Canada seniors prefer age restricted housing (Perk and Haan 2010, Shiner et al 2010).

A couple of the seniors we spoke with had moved into retirement communities with family members or friends as a way of maintaining daily activities and supplementing formal care. For instance, Jessica and Loretta are a mother and daughter who have chosen to live together as a way of dealing with the care needs of their family. Loretta's husband has had a stroke and her mother Jessica requires care as well. Loretta is 65 and is retired herself. By living together, they

are able to pool their financial resources and Loretta can help care for both her mother and husband at the same time. In their words:

> And I said to her: ‘why don't you retire?’ Because Bob [Loretta’s husband] had had a stroke ... And I moved up here when I retired. So I [said]: ‘why don't you retire and come down and we'll take a house together?’ You know ... pool our resources (Jessica).
>
> And that's what we did (Loretta)

The retirement community they live in provides a number of services and activities. According to Jessica and Loretta:

> They look after your lawns. They mow the lawns. (Jessica)
>
> If you want them too, I did this year. I'm going back to my lawn mower next year. [They] plough the snow. (Loretta)
>
> Yeah, they do (Jessica)
>
> Except for … the walkway, your own stairs and walkway, and they'll plough the driveway. And they're very good as far as anything needs repair or anything, you just call them, they put in a work order and they'll be here. (Loretta)

There is also a community center that provides a number of activities for residents of the retirement community they live in and the day before we interviewed Jessica and Loretta, they had attended a holiday party at the community centre. They said:

> You have a house down here, double, that is the hermitage, and there's lots of cards being played there. (Loretta)
>
> We were out last night. They had given us a Christmas party. (Jessica)
>
> The board. (Loretta)
>
> Yeah. (Jessica)
>
> And it was lovely, wasn't it? A three-course meal, dance afterwards, and music before, it was very nice. (Loretta)

6.4 Assisted Living

Seniors who reside in assisted living facilities have access to a variety of services provided to them such as: laundry; snow removal; meal preparation or cafeterias; health care services; transportation; and activity centres. To illustrate, Rosie, a senior we interviewed, lives in an assisted living complex where there are different levels of care depending on the resident's needs. Her apartment includes basic maintenance and repairs (hers was in the process of being renovated when the interview took place), as well as additional services to facilitate independent living including: an on-site cafeteria, a beauty salon; and medical services including a nurse and doctor. In addition a worker from the Voluntary Order of Nurses (VON) comes every two weeks to offer foot care. According to Rosie:

> There's a nurse on duty downstairs…. And there's a hair salon down there and a little store…. a cafeteria also … And you can get your meals if you wish, you know. You pay extra for the meals but if you want to do your own, then you have that privilege (Rosie).

6.5 Foster Families

An innovative suggestion to came out of the focus group discussions concerned the potential for 'foster families' to address situations where seniors lack informal support systems, particularly in rural New Brunswick. In the words of one social worker:

> One service that isn't used much for seniors, unlike for young people is alternate [foster] families. Like with home services, I think they should be used with the elderly. We could pay alternate [foster] families among family members (SW 4, FGA).

While none of the seniors we interviewed lived in a foster family arrangement, it is one that is often found in community based programs, for example, adult foster care has

been used in many places in the United States (Braun and Rose 1986, DHS 2011, Fetterman and Chamberline 1994, Kane et al. 2006, Kraus et al. 1977, Mehrota and Kosloski 1991, Reinardy and Kane 1999, SD/DS 2011, Stark et al. 1995, UDHS 2011, Woodruff and Applebaum 1996), and at least in the late 1970's in the Niagara region of Ontario (Kraus et al. 1977). For example, Michigan offers:

> Adult Foster Care (AFC) homes [that] are residential settings that provide 24-hour personal care, protection, and supervision for individuals who are developmentally disabled, mentally ill, physically handicapped or aged who cannot live alone but who do not need continuous nursing care. (DHS 2011)

A number of other states also provide for foster care for older adults including: Arizona, Utah, and South Dakota. Research shows that adult foster care is a cost-effective alternative to institutional care, particularly in rural areas (Fetterman and Chamberline 1994, Kraus 1977 et al., Reinardy and Kane 1999). Foster families are typically screened, trained, and licensed before they may operate an adult foster home (Braun and Rose 1986, DSS 2011, UDHS 2011, SCGA 2011); and most adult foster care programs are based on four assumptions general assumptions:

> (1) Nursing homes have detrimental psychological and social effects; (2) a family setting is inherently superior to an institutional setting; (3) adult foster care homes represent 'a less restrictive care environment; and (4) foster care is a desirable part of a continuum of long-term care. (Reinardy and Kane 1999:572).

While the demographic characteristics of seniors living in nursing home and those living in adult foster care homes are similar, Reinardy and Kane (1999:576) found that residents of adult foster care homes were far "less likely to have been admitted form hospitals," to have serious disabilities, or to experience serious health problems such as advanced dementia.

Adult foster care offers residents a family setting as opposed to nursing homes which reflect the medical model and this is something valued by the seniors who live in adult foster care homes (Braun and Rose 1986, Reinardy and Kane 1999). In particular seniors appreciate adult foster care that affords “privacy, a home like environment, a safe supervised place to live, and flexible rules and routines” and opportunities to interact with children (Braun and Rose 1986, Mehrotra and Kosloski 1991, Stark et al 1995).

6.6 Discussion

Living arrangements and type of housing are not only a critical component in how seniors experience the aging process, they also profoundly impact on a senior’s ability to continue to live in non-institutional settings (Alcock et al 2002, Bérengère et al 2009, Braun and Rose 1986, Crist 1999, Hays 2002, Kane et al. 2006, Shiner et al 2010, Stark et al. 1995, Trottier et al. 2000, Woodruff and Applebaum 1996). Moreover, demonstrating the importance of home support for independent living, Crist (1999) found that residents of assisted living facilities reported experience the highest levels of personal autonomy and quality of life, followed by living at home, and then residents of nursing homes (Crist 1999). According to Florence:

> And of course some, some day and I never know when it will be, I will need help in my house more than just cleaning the house. And so when that time comes, I'll feel that's very important, because I don't want to go to a nursing home as long as I can get out of bed.

In a large scale study of alternative living facilities for seniors in the Atlantic Provinces, Shiner et al. (2010) with the Atlantic Seniors Housing Research Alliance

(ASHRA) found that seniors living in Atlantic Canada were not aware of available housing programs and spent a disproportional amount of their income on housing. They also assert that there are many barriers to aging in place including: limited income or finances, illness, inadequate informal supports, a lack of funding to do home repairs, and a lack of transportation. They also argue that changes need to be made to the building code to ensure that all new housing is appropriate to aging in place. For example, new housing should include wide hallways to accommodate wheelchairs and bedrooms situated on the ground floor (Shiner et al. 2010). Universal housing design benefits all in society.

7. Issues in Case Management & Assessment

A central issue in the assessment and case management of home support for seniors is that at the same time case managers and/or assessors are engaged in determining appropriate services for their clients, they are also engaged in managing system resources. When the interests of their clients conflict with the interests of the system they can experience "difficulty … adhering to [both of] these goals" (Corazzini 2000:93). According to one social worker who took part in the focus group meetings:

> I feel that financial services don't necessarily meet the client's needs. That is a big deficiency in the program. For Long Term Care I understand that there are restrictions and that they must be applied, but in my mind this is a major deficiency, always having to manage finances, being obliged to always drop certain client needs versus others…. We know we have to play the system, put money in. We go by the tasks that can be justified. Housework can be justified, meal preparation, It's much harder for us to justify the need for supervision. (SW4, FGA)

Therefore it was not surprising that the social workers we spoke with advocated home support assessments that are needs-based (Hardy et al. 1999, Lloyd and Taylor, 1995, Parry-Jones and Soulsby 2001, Janlöv et al. 2006). Indeed, throughout the focus groups meetings they drew distinctions between the assessment for home support for seniors and assessment within the Disability Support Plan (DSP). They said things like: "[DSP assessment is] more flexible. You get to make up the case plan to fit the client, you don't put the client in a box" (SW5, FGB). In particular they pointed out that this kind of assessment takes account of individual life circumstances and is not only about informing clients what services were available (Hardy et al. 1999, Janlöv et al. 2006). In the words of one social worker who took part in this research:

> I've set up case management services for people in the disability support program, and I like that piece of it, where you're designing something that works for them whether it's getting to movie on a Friday night, or having an outing for bowling on a, you know Thursday evening, or something …. it's just good because it's just more tailored to meet the client's needs as opposed to just pulling out this menu of services, the options that are available. (SW11, FGB)

One aspect of the assessment process for home support for seniors these social workers found limiting is that for clients to be eligible they had to disclose three unmet needs of daily living, a criteria some found arbitrary in that it didn't recognize cases of legitimate need. In their words:

> A lot of the need is keeping the house up. But the problem is that in order to qualify for the program, they have to need help with personal care. (SW10, FGB)
>
> Or have some level of dementia. (SW7, FGB)
>
> In order to qualify for the program they have to what? (SW8, FGB)
>
> Need help with personal care or bathing. (SW10, FGB)
>
> Not necessarily if you have three unmet needs under the IDL. (SW8, FGB)
>
> Yeah, but most, you know, if they're not able to wash their floors, and like, keep the house clean and tidy then they're not going to qualify. (SW10, FGB)
>
> Oh, it's one unmet need…. (SW8, FGB)
>
> I find that … even though, maybe, they can have a bath totally fine on their own... so you have to look for things…. Like you have to ask them if maybe they need someone there just in case they're going to fall, you have to always be looking, especially if you go in and see the need…. You have to look, and dig for things. And a lot of times seniors don't want to admit that they need help…. And some people will reapply, like I have a couple who applied in January and they didn't qualify and they were quite upset so I had to send out the letter 'cause they didn't have unmet needs, and I had to explain what unmet needs they don't have, well now they just applied again…. and they know what to say. I don't think that their needs have changed [laughter), but now they know what [to say] (SW10, FGB)

Another social worker added:

> The other part of that is too, when you've got someone who has a mental health issues, it really creates a problem because sometimes can they physically do so something? Yes. Do they have the wherewithal to do it with their mental health issues? How do you score that? Is it a 3, is it a 4? I mean, you have to have 3 scores of 4 under the IDL's which means you have to have 3 things that you can't do for yourself. Well, if you've got 4 things that you need help with why isn't that eligible? You can't do it by yourself you need help with them. But that doesn't get you in, so you have to you know – (SW9, FGB)

7.1 Menu Driven Assessment

Moreover, the assessment tool used shapes the assessment process and over-reliance on it can result in a failure to note individual concerns and unique needs (Chernesky et al. 2008, Richards 2000). For example, the social workers we spoke with told us that the menu of services they use in assessments is overly rigid and didn't allow them to address client needs in an effective way. For example, during one focus group meeting they said:

> Part of the process is hearing from the client – what is it that you need? That's part of the interview process…. Sometimes it's far, far fetched, but I hear what you're saying, to go down by this menu of service and not be able to go outside the box can be difficult for some of the clients. (SW8, FGB)

> I go out sometimes and do assessments and in my head I can come up with things that might benefit the client but it's not on our menu of service, like, for instance, like if I client doesn't have competence, like competency issues you know cognitive decline, then we can't, we can only put so many hours in typically because just to help them with you know housekeeping, meal prep, and that kind of stuff, or physical issues, but, there could still be a risk of falls. So something like Lifeline would be a good thing to be able to have on our menu of service, and it's not right now. (SW5, FGB)

Thus, these social workers experience assessment as menu-driven and governed by government and home support agency rules. To illustrate, meal preparation is an

eligible item of homemaking service while having a homemaker drive the client to do grocery shopping, or providing taxis for that purpose, is rarely a service the social workers we spoke with are allowed by their supervisors to approve. As one social worker told us:

> We can't even approve a taxi once a week for somebody to go out and get their groceries, never mind having somebody take you…. 'no, we're not paying for a taxi unless you need assistance getting in and out of the car.' That's the only exception. (SW6, FGB)

This is despite the fact that seniors identify a need for transportation as among their most critical of needs (Chernesky and Gutheil 2008). The lack of flexibility these social workers identified with the menu of services meant that other important needs could not be met. For instance, when we asked the social workers who participated in the focus groups about the issue of snow removal they told us:

> That's not on our menu….. I go out sometimes and do assessments and in my head I can come up with things that might benefit the client but it's not on our menu of service, like, for instance, … Lifeline would be a good thing to be able to have on our menu of service, and it's not right now. (SW5, FGB)
>
> It is in some regions. (SW8, FGB)
>
> It is in our region. (SW7, FGB)
>
> It's not in, it's in our policy, I've read it in our manual, but it's (SW5, FGB)
>
> It's always been there but we were only allowed to do it for a very short time, and then they realized it was on a menu, and said: 'oh no, no, no, you can't do that.' (SW9, FGB)

7.2 Creative Case Management

Rather than being constrained by a menu of services, the social workers who took part in the focus groups want to exercise discretion within a set budget as a cost

effective way of better serving client needs as illustrated in the following excerpt from one focus group meeting:

> One way would be to look at one of the biggest unmet needs of seniors that aren't being met based on our menu of services to see what we could possibly add, but I think that there just needs to be NOT a menu of service but just some flexibility…. Say: 'this is how much you can spend on a case plan …If you go over this you need to go higher up. But this is how much you have…. do you think you could make a case plan with this. (SW5, FGB)
>
> Give us some discretion with our supervisors to make some decisions. Give us some discretion…. (SW7, FGB)
>
> I would sit with my client, and I do right now, so what do you think you need? And we sit and we talk about it together. But in saying that I know what I'm going to be able to provide, it's not on my menu of service. But if I didn't know that, if that wasn't there and I just knew it had to be, I knew this much, I could build a plan with them, and a lot of it probably would be on the menu of service. (SW5, FGB)
>
> So you want some, you want a little more flexibility in tailoring the plan, but you also want to add some services, like transportation (SW6, FGB)
>
> Right (SW5, FGB)
>
> I see that as a big problem. (SW6, FGB)
>
> Help to get groceries. (SW5, FGB)

A central and persistent theme emerged from the focus group discussion with social workers was their desire for increased flexibility regarding the menu of services. One social worker argued that this would enable case managers to "think outside the box" (SW3, FGA) in order to address unmet needs and improve the services provided to seniors. Social workers could then creatively address the many situations presented to them on a daily basis. In particular they said that if assessment for home support was

more like assessment in the DSP program, they would be better able to tailor plans to the individual circumstances of seniors. In their words:

> We call it the DSP [Disability Support Program]…. [It's a program where] we don't have a menu that tells us what to give people. Okay, we know we have financial parameters, but we can play with them, in the sense of which services we're going to provide. For me, that responds much better. (SW4, FGA)

Another social worker we spoke with, who works in crisis intervention and thus has a far smaller caseload than most case managers, gave an example of what 'thinking outside the box' in case management of home support might look like. It is a situation where case managers assume as part of their role the responsibility for coordinating formal and informal systems of support to enable seniors to live successful daily lives. She put it this way:

> So, for instance in this situation I'm working in right now, client's blind, has a couple dogs can't manage their care, needs them for companionship, mourning the loss of a wife, desperate situation with being unable to even look after these animals. Well, his main need is not to lose them. The SPCA is sending in volunteers to help him. They're sorting out grooming and, that's not really a concern to me whether his dogs get groomed, but it's a huge concern to him. And he also needs training, once he's come to accept the fact that I'm not going to regain my vision, I am completely in darkness, and this kind of desperate situation, now he's saying I'll accept white cane training. That's a volunteer service. No one's being paid to do that for him, but I can coordinate that for him. (SW11, FGB)

7.3 Assessment/Case Management Split

An issue that occupied the lion's share of discussion within the focus groups was the separation of initial assessment from on-going case management duties. The social workers we spoke with overwhelmingly favoured a system whereby the case manager

would also conduct the initial assessments for home support services. In the words of one social worker:

> I had the opportunity to see it done three ways, and I would strongly support in terms of service delivery, in terms of working with such a vulnerable population, [the] approach that I've seen work the best was that you had your region, you were the case manager and any new situation that came in you were the one that did the assessment. That's the best way, it worked in three weeks [and] we don't have waiting lists. They usually argued that the waiting list is because our population is aging. I don't agree, I've seen it and I would rather do the initial assessment as well…. And follow it through. (SW8, FGB)

These social workers told us of a host of problems they encounter due to the split between case management and assessment, including: confusion for both clients and case managers; unnecessary delays; loss of information; and, in the end more costs to the system. They began by highlighting the confusion separating case management from assessment caused for clients. In their words:

> It causes problems. (SW4, FGA)

> That causes many problems, they're confused, they don't know who their case worker is. (SW1, FGA)

> They have no idea, they call the Department and say: 'My name is [so and so] who should I call?' (SW3, FGA)

> I can tell you that now that I'm only in assessment, they all come to me. Because I'm the first person. (SW4, FGA)

> That's right! (SW3, FGA)

> They saw me. They liked how [I did things] so it's me they call…. (SW4, FGA)

Similarly, when we asked the seniors we interviewed if they knew who their case manager was, only one was able to tell us. Others said things like this:

> Do we have one? (Paul)

> Is there a [so and so]? She's the one who made the assessment. There's somebody else whose, another name that was, who said: 'this is the person to contact,' … I don't think it was the same one that came and did the assessment. (Joan)

The social workers went on to describe the confusion this split causes for them in their efforts to cope with their ever-expanding caseloads. In the words of one social worker we spoke with:

> I would put the needs assessment and the long term care ongoing [case management] back together. What we always did was that you had a geographic area, and everybody … who was needing services, they knew who to call. You'd go to them, you found out the information yourself, you got to know the family, you got to know the information on this person and you carried the case. Now it's a matter of out of the blue you get a file, you may not even see them for a year because your geographic area now is so big, and you've got so many more clients that you don't know this person at all, so it's like every time something comes up on a new, newish client you have to start at the beginning because you have to go all the way through the [files] and find out what's going on … whereas if one worker was assigned to it the family would know who to call because normally they call needs assessment, needs assessment has to call us and pass it on, and, and it just makes a lot more difficult to deal with ongoing clients…. they don't know who to call, you don't know them, if somebody calls me and says: 'This is your client' I think 'this is your client so and so?' and I have to dig out my caseload list, and I mean that's offensive, to have to look up on my caseload list to know if they're my client. (SW9, FGB)

Not only does this cause confusion it also adds to case managers' workloads, again adding to the cost of the delivery of home support services. According to several social workers who took part in the focus group meetings:

> They pass it on to what's called case management so any changes that occur after the fact, the case, the person who's the on-going case manager deals with. But the seniors, in a lot of cases these are seniors and they get confused, and they get frustrated because they're calling the first person because that's their only connection, and then that first person also has to have more work because they're always, you know, having to deal with those phone calls and saying "no, no, no, you gotta call the ongoing case manager" so it's frustrating for them as well. (SW6, FGB)

> I still get calls from the public because so and so told so and so that I was the worker, and I also get calls – the hospital – and Extra Mural invariably call me and say well, "you know, we weren't sure who it was, so you won't mind just looking that up," and it's like [laughter] you know you don't mind it when it's once, but when it starts you know, like every other day you get (SW9, FGB)

The social workers who took part in this research told us that separating assessment from case management caused delays in the delivery of home support services to seniors. In their words:

> It's almost double the time… (SW9, FGB)
>
> It is! (SW6, FGB)
>
> …getting the assessment done (SW9, FGB)
>
> Especially out in the rural areas where you have to travel an hour to get there, … because you can't go on what someone else has written totally. (SW6,FGB)
>
> We used to, when somebody called, brand new person, we used to be able to be out and do it within, probably 3 weeks, to get the services started. Now if it's 3 months you're lucky, because … the financial has to be done first, which means you can't do it concurrently. (SW9, FGB)

These social workers also told us that delays and overlap cost more in terms of human and financial resources. According to one social worker we spoke with:

> It's repetitive. It's repetitive. It's difficult for the client to have to deal with three different people, and it's a waste of time and money for the government, because it's, if I have to go back there and start from scratch. (SW6, FGB)

7.4 Follow Up

A significant issue in the case management of home support services for seniors in New Brunswick is the lack of on-going follow up after the initial assessment for services when the case has been opened. All but one of the seniors we interviewed for this research told us that there had been no follow up on their initial assessment and the

social workers who took part in the focus groups told us that regular and on-going follow up in is impossible given the size of their caseloads. In their words:

> We've all got 180 to 190 [cases], whether you're travelling within the city or whether like, I'll travel an hour away…. (SW6, FGB)

> And I think that might be why the child protection method of you know how they do assessments and then it goes to an on-going [follow-up], isn't quite working for the seniors, because with the child protection, although they're really overworked as well, their caseloads are a lot smaller, they carry 15, about? ….So they can go out … and meet with the family right away when it's sent to them, whereas when I send something to [a case manager] she might not meet with the family until they call in a crisis, right? (SW5, FGB)

> Well, that's usually what happens I do crisis management, whatever is the most important thing for the day, and then there's the odd day where I can say: 'Okay, there are no crises today, so who what can I review or who can I call to check in on or check' you know, that's the way it goes. You don't manage a caseload by saying: 'I'm going to review everybody every six months or once a year.' It's 'who's called me today' and 'what's the most important thing that I have to do.' (SW6, FGB)

7.5 Discussion

The social workers who spoke with us told us that they struggle with large caseloads that preclude case management that is anything other than crisis management. Particularly given the additional work created by the decoupling of assessment and case management, and the overly rigid menu of services that constrains them from addressing the individual and unique situations of their clients. They maintained that they would be better able to do their work if they were given more flexibility in establishing the care plan for the clients which in turn could lead to more efficiencies in the system as they would be better able to tailor care plans to client needs.

8. Rural Home Support

Notwithstanding the need for and benefits of home support in rural areas, delivery of such services in these areas is problematic (Kenney 1993, Forbes and Janzen 2004, Hollander and Prince 2007, McAuley et al 2004). This is a particular issue in New Brunswick where almost 50% of the general population, and 15% of those over the age of 65, live in rural parts of the province (Dandy and Bollman 2008, GNB 2006a). Most difficult is recruiting and retaining support care workers (CHCA 2008a; CPA 2008; Petitpas-Taylor 2009; VON 2008). A difficulty compounded by the time and money home support workers must spend on travel (Morgan et al. 2002, McCann et al. 2005). Problems made worse by the "condition of rural roads," especially in winter (Skinner et al 2009, McCann et al 2005:466). For instance, Genvieve, one of the seniors who took part in the interviews who lived in rural New Brunswick told us that she experienced difficulty with the reliability of homemakers. In her words: "They were missing too many days and you still have to pay them or else they don't come. And it was winter time, eh, and storms and all that, and they lived way up." These and other issues associated with the delivery of home support in rural New Brunswick, including: the dearth of community groups and programs for rural seniors; out-migration of youth, as well as travel costs and other transportation problems, were identified by the social workers we spoke with.

8.1 Difficulty in Recruiting & Retaining Support Workers

Research shows that most problematic in the delivery of rural home support is recruiting and retaining support care workers (CHCA 2006, 2008a, CPA 2008, NBHSA

2009a, VON 2008), thus we were not surprised when the social workers who took part in both focus groups told us that they often experienced difficulty in finding support workers to provide services in rural New Brunswick. Members of both focus groups pointed out that the low wages paid to home support workers, in addition to the costs home support workers pay in traveling to deliver services to clients are at the root of this problem. In their words:

> It's very often a problem because we often have people in very isolated areas. We have small villages. I mean, listen, our region is fairly big…. It takes half a day, an hour to get there, an hour to do the assessment. And services aren't there; agencies are central and not everyone [support workers] is interested in travelling because they also have to pay for their gas, travelling that far. Winter is severe as and [all they receive is] minimum wage for the work they do. (SW1, FGA)

Another factor making recruitment and retention of home support workers in rural areas problematic is time spent in travel and costs of travel incurred by home support workers (CHCA 2006, Morgan et al. 2002, McCann et al. 2005).

> Well, paying for transportation is a big one. (SW6, FGB)
>
> Yeah. (SW7, FGB)
>
> If you have a person in a rural area and their homemaker lives, you know, 15 minutes away, or even further, there's nothing in place that will compensate them for their transportation so, first of all they're getting minimum wage and no money for transportation. (SW6, FGB)
>
> If they work for an agency their transportation is being covered. (SW7, FGB)
>
> Right. (SW6, FGB)
>
> So (SW7, FGB)
>
> But the agency is also taking a big percentage out of what they're getting paid (Facilitator 1)

> ….Yeah, that's a huge problem in rural areas, transportation, bumming for transportation. Compensation, first of all, because a lot of them are private arrangements and minimum wage is not enough, and if you have to maintain a car (SW6, FGB)

In addition to the problems of low pay and travel costs is that home support agencies are reluctant to supply workers for rural areas unless they are guaranteed a minimum number of hours, often an amount of time that exceeds what a senior is assessed for. Members of one focus group put it this way:

> Most agencies won't send their workers out though, to the rural areas. Like if I was to call agencies even though we don't have anyone (SW5, FGB)
>
> Or 'we won't send them out unless it's for a big chunk of time.' (SW6, FGB)
>
> Minimum of three hours, a lot of places. (SW7, FGB)

8.2 Dearth of Services & Programs

In addition to the problem of supplying support workers in rural areas of New Brunswick is a lack of community programs and services for seniors in rural regions of the province. When we asked focus group participants what kind of organizations there were for seniors in rural communities on social worker initially reacted with derision. In their words:

> So in these rural areas, what kinds of community groups are there? There's churches, there's the Legion, that's, that's about it? (Facilitator 1)
>
> Are you Kidding? (SW8, FGB)
>
> No I'm just wondering about other groups that may be you know, again talking creatively about new partnerships and things that could be brought to help with that kind of isolation that you're talking about. (Facilitator 1)
>
> Like, even if the Alzheimer's group would go one day a week or one day a month up in that area, so that they wouldn't have to travel all the way to

> Chatham, it's an hour drive, that discourages them and they don't go. (SW8, FGB)

> And that's the way it is with most groups. It's, if you do have that group represented in the community it might be one day a month that they pop in, and if you're not available that day or don't have the transportation to get there, too bad. You know. (SW9, FGB)

Nor are there necessarily day centres in rural areas of New Brunswick. According to one social worker who told that there are "limited resources" in rural New Brunswick. She said: "We don't have daycares like they do in Moncton. Things like that for … people, providing families with relief…. We don't have much of that" (SW1, FGA).

A consequence of the dearth of programs and services for seniors in rural is loneliness and isolation, an issue that emerged as key in both focus groups. For example, members of one group said:

> The key aspects for me are adequate nutrition, proper medication management and stimulation in rural areas, and I find that in the rural area that stimulation aspect, there is no day program there. And I can, and when I do assessments in the city it's great you know, there's a bus that'll go pick them up they can go spend the day it's cheaper for the government but … as soon as you reach a certain part outside the city that service is not there for those people. (SW8, FBB)

> Some people never get out of their house for months at a time. I would say: 'when was the last time you were actually out of this house.' (SW6, FGB)

8.3 Transportation Problems

In addition to the scarcity of programs and organizations, is the lack of transportation in rural areas, making even common everyday services less accessible for seniors in rural areas (Morgan et al. 2002, McCann et al. 2005, Schoenberg and Coward 1998, Thompson and Postle 2007). According to one focus group participant:

> I mean when you look at somebody who's away, like they aren't right in the main centre…. So they don't have access to any of those, they don't have the Tim's, they don't have the bank that's just down the street. I mean it's 20 minutes or 30 minutes … just to get to where those are located. (SW 9, FG B)

Also problematic is that time spent in travel in the assignment of caseloads for the social workers who case manage home support services for rural seniors. According to two social workers who took part in the focus groups:

> They don't distinguish between whether you have a city caseload or a rural caseload here, we've all got 180 to 190, whether you're travelling within the city or whether like, I'll travel an hour away. (SW6, FGB)
>
> Yeah, and there's a huge difference. (SW9, FGB)
>
> And Moncton apparently has an even higher caseload. But other regions have much lower caseloads and so, you know, you can't deliver the same quality of service if you have higher numbers. It's just not possible. (SW6, FGB)

Given the problems inherent in the rural delivery of home support, it is not surprising, as one social worker told us, that many social workers prefer urban to rural caseloads. In her words:

> We all have our geographic … areas, we don't have rural areas, but the city ones, our supervisor assigns them out depending on our task list, 'cause we all want to do some of the city ones because they're just easier. (SW7, FGB)

Rural travel is made even more difficult by the "condition of ... roads" (McCann et al. 2005:466), especially in winter (Skinner et al 2009, McCann et al 2005). Further, administrators of home support agencies have "concerns about [the] coordination, liability, and insurance related to traveling to homes and communities under winter conditions" (Skinner et al. 2009:685). Both are significant issues in New Brunswick where northern rural parts of the province can receive thirteen feet of snow in a single

winter and where snow shovelling is not one of the home support services offered. As one focus group participant put it: “that’s not on our menu of services” (SW 5, FGB).

8.4 Out-Migration of Youth

Forbes and Edge (2009) point out that while staff shortages in the delivery of home care and home support are not issues unique to rural areas, they affect rural areas to a greater degree due to the more rapid aging of rural populations and the out-migration of rural youth seeking employment in urban centres. The out-migration of youth is a particular problem in New Brunswick and one experienced by almost all the seniors who took part in the interviews for this research (Beale 2008, Haan 2011). For example, Sally, one of the seniors we spoke with told us that home support services were very important for rural seniors “’Cause there are lots of seniors [that are] going to be [in need] ,,,, especially in this area, because there's really not much work, so there's not a lot of younger people, you know.” Likewise, in the words of one social workers: “See where I come from a lot of people have left the area, the kids have gone out West, there’s nobody there.…You can’t rely on family, in the city it’s easier” (SW8, FBB). The social workers we spoke with told us that such out-migration makes the need for home support in rural areas even more critical than it is in urban ones, and makes the need for home support workers even more acute. As one focus group participant put it: “There are circumstances where everybody has moved away and those people I think we have to look at differently, they don’t have the resources” (SW7, FGB).

8.5 Seniors & the Digital Divide

In addition to transportation and community services and programs, infrastructure lacking in rural areas of New Brunswick is Internet access. For instance, when discussion in one focus group turned to the possibility of online grocery shopping as a partial solution to issues faced by seniors in rural areas who lack informal support and access to transportation, it was deemed a "a non starter" (SW 6, FGB).

> I'm going to throw something out, and it's not appropriate for everybody because there are financial issues and there's a digital divide, but for some people in isolated areas, could online grocery shopping [help]? This doesn't solve the problem of getting them out of their house, and keeping them from being isolated, but it might get them food. (Facilitator A)
>
> The seniors do it online themselves?... (SW5, FGB)
>
> Some of them? (Facilitator A)
>
> Most rural areas don't even have proper internet connection. (SW5, FGB)
>
> ….If you're not right in Saint Stephen….then it depends on what tower is available at the time, if you have a cloudy day, it cuts out. If you, I mean it's just insane. (SW9, FGB)
>
> A lot of seniors at risk or with low incomes have no computer access (SW6,FGB)
>
> Or may have no computer skills. (SW5, FGB)

Likewise, very few of the seniors who took part in the interviews said that they used computers. Pearl summed it up this way: "Well I guess I don't own a computer. [Laughing] I don't think I want one."

8.6 Discussion

During the focus group discussion of rural delivery of home support, one social worker told us that: “even in rural areas there are sometimes, you know, family” (SW7, FGB). So despite the very real problem of children leaving New Brunswick, some family members do stay (Baer and Curtis 1984, Beale 2008, McCann et al. 2005). Similarly, the seniors who took part in the interviews who lived in Northern New Brunswick did not recount the same stories of social isolation and problems in accessing home support or community services recounted by the social workers we spoke to. In contrast to what we heard from social workers and what is a persistent finding in research, all but one of the seniors from rural areas that we spoke to said that their homemakers lived locally. In Linda’s words they were “from the area.” This difference in findings reflects the crisis mode these social workers work under which means they only see crises and problem situations, and because they have no time to do follow up on a regular basis, they don’t get to see the situations where everything is working well; situations incidentally where seniors were also more likely to contact us to participate in this study. What this difference in findings also suggests is that while the problems associated with the delivery of home support in rural areas are not universal, this does not mean they are not real and are not critical issues to address. In the words of one social worker:

> I’m a big defender of rural communities because … we don’t have the infrastructure for one thing and because our people live in more isolation for another and because we don’t have the staff, for another…. It’s not [just] a matter of travelling from one client to another. I feel that if there is one place where we should be more permissive in terms of the service menu, it's maybe in rural communities because they don't have the infrastructures. We don't have buses to transport people (SW4, FGA).

9. Client-Directed Home Support

Client-directed care emerged in the 1970s out of the independent living movement, which sought to ensure that people with disabilities have the same rights to autonomous living as those without disabilities (Spalding et al. 2006). While there has not been an equivalent "consumer-driven independent living movement per se among older people … or their families," the goals of the Independent Living Movement are of relevance to seniors and home support (Eustis 2000:13). New Brunswick currently offers a form of client-directed care where seniors or their families determine hiring and firing of workers, although family members may not be hired (Spalding et al. 2006). Clients then submit hours and workers are paid through the Long-term Care Program. In the words of one social worker we spoke with:

> We have what are called private letters of agreement, so instead of an agency providing a person to go out that they pay and that we monitor the client gets to hire a private person and pay them, and then we reimburse them. (SW6, FGB)

Almost one third (29%) of recipients of home support in New Brunswick have chosen this option (SD/DS 2011). Consistent with research that advocates client-directed models of care a partial solution to the delivery of home support in rural areas, the largest proportion (between 61% and 64%) of seniors receiving home support via a private letter of agreement reside in the rural regions of Miramichi and the Acadian Peninsula (SD/DS 2011). While the social workers who took part in the focus groups cautioned that each case has to be evaluated to determine whether or not a private

letter of agreement is appropriate, those social workers who provide service in rural parts of the province supported this kind of client–directed care. For instance, one said:

> There's no question that this should be looked at individually. I mean, I have clients who are really isolated. There's no one in a small community to provide the service and there's a real need. (SW3, FGA)

Likewise, Loretta who lives with her mother Jessica in rural New Brunswick told us that she thinks client-directed care "makes sense." She and her mother went on to say:

> We kind of have that now because we use [agency workers] for the 40 hours and for the eight hours of relief … I get a friend to come in. She used to be our worker but she had an accident and so … we went with [the agency] but she comes in now two nights a week … for four hours each. I had to go and see the caseworker and he had to get her set up…. so that when I turned her hours in at the end of the month. (Loretta)
>
> She would get paid. (Jessica)
>
> But he [the case manager] said there was no problem with it. (Loretta)

A particular objective of client-directed care is to give individuals more control over their care provision. These models generally include services that are social and supportive such as homemaker chores and personal assistance, as opposed to extra mural medical services (Benjamin 2001). Much of the literature on client-directed home support points to the efficacy of client-directed over case-managed service provision (Benjamin et al. 2000, Glickman et al. 1997, Simon-Rusniowitz et al., 2002, Spandler 2004, Thompson and Postle 2007). In particular, client-directed support services are argued to lead to positive outcomes among users including fewer unmet needs (Benjamin et al. 2000, Carlson et al. 2007, Clark et al. 2007, Foster, et al 2003,

Hagglund, et al 2004, Kim et al 2006, Matthias and Benjamin 2008, Spandler 2004, Wiener et al. 2007). According to one social worker we spoke with:

> I do see some value in client-directed approaches, because people are experts in their own lives, right? I mean we all know that. They know what their needs are better than I do from running in and seeing a crisis and assessing them for what services and supports in my menu of services that I might be able to thrown in their home. (SW11, FGA)

Client-directed service provision also allows service users to play an active role in directing the nature and type of care they receive. One way this is accomplished is by having the client rather than an agency be the actual employer of the support workers, however, this also means that they are typically required to recruit, hire, supervise their workers, and manage a budget (Benjamin 2001, Spalding et al. 2006). In some cases they may also be required to take on payroll and other bookkeeping tasks such as: "managing money, time and personnel; making payroll deductions related to CPP, EI, Income Tax, WSIB; and following occupational health and safety standards, and workplace safety and insurance requirements" among others (Spalding et al. 2006:69). Some models of client-directed support involve an intermediary, such as a government department that takes care of all payments (Benjamin 2001).

Not surprisingly, the administrative responsibilities that accompany client-directed approaches were not ones most of the seniors we spoke with wanted to take on. For example, while Linda expressed interest in being able to be in charge of who was hired to provide home support, and told us: "there's a lot of people that … that we know, who would, if they were paid for it, they would come and do the work," when we explained that she might have to assume some payroll responsibilities she replied: "Oh, oh, oh. That's work I wouldn't want to do." Seniors more willing to perform the administrative

tasks associated client-directed approaches are typically younger and have prior experience in managing workers (Benjamin 2001, BC Ministry of Health 2008, Desmond et al. 2001, Feinberg and Whitlatch 1998, Mahoney et al. 2002, Simon-Rusinowitz and Mahoney 1997). So too were the only seniors we spoke with who showed an interest in the administrative work that client-directed entails. These seniors were all under 75 years of age and either had high levels of education or had had work experiences that entailed bookkeeping or hiring, firing, and training workers. For instance, when we explained to Loretta that she might have to keep track of payroll and perhaps do tax remittances, Loretta, who is just 65 years of age and had worked as a credit manager, said: “In our situation, it would be fine because we live together and I can look after the paperwork.” In contrast, Sally, who was 91 at the time we interviewed her, said: “No I don't think so…. I don't like to handle anybody else's money.”

9.1 Hiring Family

Almost all of the seniors we spoke with, who had family members available, would like to have them provide home support rather than being required to accept an agency worker or other stranger. For instance, when we asked informants if they would like to be able to hire a family member, they said things like:

> Oh yeah, yeah, I think I would rather have that,… I think I would rather have somebody from the family…. I think you’d feel more at ease. If there’s something that’s not done correctly you can say: ‘well, why don’t you do it like that,’ or, you know, different things…. A stranger, well, you’re, you’re afraid you’ll hurt their feelings … sometimes. (Linda)

> [The] benefit for me is having my family around me and I enjoy that. It's not somebody… that, I don't say I didn't enjoy the teenagers [agency homemakers]…. But you notice it's nice to have your own looking after you,

> doing things for you and not that the girls that do for me [don't], they're very good, but It's not the same. (Jessica)

Likewise, Francophone social workers saw the benefits of having family provide client-directed home support services. In their words:

> The person would probably be much more comfortable with a family member. You need a daughter-in-law who would say, I'll quit my job but I have to work. I need a salary. That would be a trade-off because you'd still have the elderly person who would be with the comforting person and you'd have the daughter-in-law who would be paid and would stay home with that person. (SW3, FGA)

> She knows her well. (SW1, FGA)

> She knows her well … when you come every two or three days, it's different. (SW3, FGA)

In contrast, some social workers in the Anglophone focus group were critical of any model where family could be hired, suspecting that such arrangements were more vulnerable to fraud and abuse. According to one social worker:

> I mean there's already a lot of fraud associated with private [letters].... There's a lot of fraud that goes on where people are signing off on things that didn't actually do the work. (SW6, FGB)

However, other social workers in the Francophone focus group pointed out that where fraud and abuse are concerned, "the same thing can happen with agencies too" (SW4, FGA).

9.2 Discussion

There are researchers who argue that there is more potential for exploitation, fraud, and abuse in client–directed models of service delivery, especially those allowing family members to be hired to provide home support (Blaser 1998). In particular the fear is that family members might collude in misrepresenting hours of care provided in order

to collect larger payments (Blaser 1998). Such fears are often echoed by managers of home care agencies who have a financial interest in excluding family members from providing home support services and by policy experts who worry about liability issues and negative public perceptions (Mahoney et al. 2003, Simon-Rusniowitz et al. 2002). Other rigorous research, however, demonstrates that there is actually little incidence of fraud and abuse when consumers receive a budget and pay their own providers, whether providers are family or non-family (Benjamin 2001). Moreover, research designs that control for client demographics, case mix, and service resources show that type of service model is not a predictor of abuse (Matthias and Benjamin 2003). None-the-less, the social workers we spoke with stressed that "there has to be some accountability" (SW6, FGB) in client-directed service provision. As important, they told us that there should be a range of options available:

> Private service [providers], family, and everything. There are exceptions, there are times when they accept family members, but there are still conditions in the sense that there are no resources from the organization available in that region. The province still has to look at certain criteria. (SW4, FGA)

10. The System

A great deal of the discussion during the focus group meetings with social workers centred on issues they saw as systematic in the long term care program. In particular they perceived a need for more standardization; additional financial and human resources; and better co-ordination with other departments or services.

10.1 Centralisation & Standardization

Social workers who took part in the focus groups told us that the system was more rational and efficient when all assessment tasks were handled regionally by social workers with knowledge of the program, who were able to determine whether someone was eligible or not for home support services during the initial phone contact. They also said that the process was more efficient when the financial assessment was not de-coupled from the needs assessment as it is now, as the following excerpt from the focus group discussion illustrates. In their words:

> When they first started having our screening down in Saint John, by phone, there was a difference because when it was done in the region you actually had a worker taking that information that knew the programs and they did the screening right on the phone. So they said, you know, if you only want one thing you're not going to be eligible…. So they screened it right then and you didn't have to have it go away on the phone. And when somebody had a financial to be done you were, the worker was already assigned, so you helped them do up the financial, whereas now they get mailed something out of Saint John. (SW9, FGB)

One social worker pointed out that when assessment information is transferred to data entry clerks without specific program training, typographical errors can occur. In her words:

> In our region.... what happens is that the financial is … put it on the computer, very often with a lot of mistakes because … [data entry clerks], they've never been trained in the different programs or at least they're not told how to screen, it's simply data entry. (SW9, FGB)

In some regions, where procedures are under more local control, social workers told us that administrative processing happens in a more timely and accurate manner. According to one social worker we spoke with:

> We do it a little differently. Actually I kind of like the approach that we use, … once after somebody calls, after it goes through data entry, it gets assigned to us and then we make the telephone contact to advise them of what the financial is, and probably like, I know for myself I'll explain to them you've got to have the income tax, you gotta sign, I'm going to highlight where you have to sign, and then I do a pre-screening, well actually before the financial I do the pre-screening, and often times I can screen them out (SW 8, FGB)

The social workers who took part in this research were also concerned about the variation in how different regional offices function with regard to needs assessment and case management. While assessment tools and polices are standardized provincially, these social workers told us that a lack of standardization of regional office procedures makes it more time consuming to sort out the paper work on the cases they manage and makes the program feel "disjointed" (SW7, FGB). For example, regional differences were highlighted by several of the social workers we talked to. According to one focus group participant:

> One of the most confusing things of doing all of this is that every region does everything so different, and if you have some assessment you're doing for another region it's just like your head spins when you try to figure out where it goes to, and who does what. (SW7, FG B)

The social workers who took part in this research told us that many procedures are confusing for the seniors who are clients of the program. In particular the social workers we spoke with told us that seniors receive forms they find confusing and cannot

fill out on their own, necessitating a second trip made by a social worker or case manager in order to give them the help they need with the form. They said:

> Out of the blue they get this form. You take an 89 year old person, they're going to look at this form with all these lines, you think they're going to be able to sit there and figure it out? (SW, FGB)
>
> I think it's very intimidating (SW7, FGB)
>
> I'd go out and help them. (SW8, FGB)
>
> Me too. (SW 6, FGB)

In addition, social workers said that the interactive voice response (IVR) telephone system that seniors must use to contact the Department can also be a source of confusion for seniors. In their words:

> But even that, it's confusing for [clients] (SW3, FGA)
>
> It's a system, IVR System.... You have to push the right button! (SW4, FGA)
>
> You can be put on hold for 20, 25 minutes sometimes, waiting. (SW3, FGA)
>
> If you didn't understand, you have to give your social insurance number. (SW1, FGA)

Negotiating such automated telephone systems can be difficult for anyone, regardless of their age, especially if not equipped with a hand-free, speaker phone. In addition automated directions are particularly confusing for older seniors. Thus the phone system becomes in effect an unintended barrier to obtaining necessary information for many seniors.

10.2 Human & Financial Resources

Notwithstanding the fact that New Brunswick invests more per capita in home support than any other province in Canada (CIHI 2007:18; MacAdam 2008, 2009), the social workers who took part in the focus groups for this research told us that they work within a context of restrictions in human and financial resources. Research shows that recent policy and funding changes have negatively impacted home care and home support programs across Canada, resulting, in particular, in reduction of the home care and home support work force (Angus et al. 2005; Aronson 2002a,b; Aronson and Sinding 2000; Edebalk et al. 1995; Livadiotakis et al. 2003; Francis and Netten 2004; Groenewoud et al. 2008; Samuelsson and Brink 1997; Sharman et al. 2008; Penning et al. 2006; Randall and Williams 2006).

10.2.1 Financial Resources

Almost all members of the focus groups argued that the home support system is underfunded and said things like: “we’re getting less and less money to work with” (SW6, FGB). In addition, some focus group participants said that they favoured more spending on home support and less on institutional care. One focus group participant put it this way: “The problem is home support. At the same time, we’ve never had so many nursing homes built in the province….” (SW4, FGA). Research demonstrates that home support is more cost effective than institutional care in the case of seniors without serious health problems (CHA 2009; Chappell et al. 2004; CIHI 2007; Forbes and Janzen 2004; Hollander and Chappell 2002; Hollander et al. 2007, 2009a,b; Shapiro and Havens 2000; VON 2008, Wilkins and Beaudet 2000; Zimmerman 2003). For

instance, Chappell et al. (2004) found, that even when informal caregiver time is valued at replacement wage, home care was still cheaper than residential care. Likewise, in their national study devoted to examining the cost-effectiveness of home care, Hollander and Chappell (2002) found home care cost 40% to 75% of the costs of facility care and Hollander et al (2009a:43) conclude that “home care has the potential, through appropriate substitutions, to be a cost-effective alternative to facility-care.” Despite the cost effectiveness of home care and home support, as well as the fact that the home care sector provides many services that were once provided in hospital settings less funding is directed towards home care than towards acute health care services (Anderson and Parent 2000, Livadiotakis et al. 2003). Moreover, advanced age, lack of a spouse at home, and low income are equally important predictors of whether or not a senior moves into a nursing home and thus highlight the need for robust publically funded home support programs (Bérengère et al 2009, Golant 2011, Trottier et al. 2000).

Other social workers pointed out that the exclusion of assets from the financial assessment may have had the unintended consequence of limiting resources for home support services. While these social workers told us they recognized that the impetus to exclude assets from the assessment was to make sure seniors did not lose their homes in order to be eligible for home support and to make sure that seniors were left with adequate assets to take care of themselves, some argued that another unintended consequence of this means of financial assessment is that it can end up disproportionately benefiting those with higher rather than lower financial resources to draw upon. One social worker put it this way:

> The income may be smaller, but if, the income for someone who hasn't got much money … they have small income, they're in desperate need, whereas if you get somebody who has a smaller income but has a huge amount of assets.... (SW9, FGB)

Other focus group participants countered by pointing out that even those with what seem to be high levels of assets are in legitimate need of publically supported home support. However, they did think it fruitful to think about ways to refine the financial assessment process. As one social worker put it: "There are many people who could be supported at home better if they made a larger contribution; partially asset-based at least" (SW11, FGB).

Members of the focus group also told us that, where services were being supplied to more than one member of a family, money could be saved by using a 'family focus' rather than an 'individual focus' in service allocation, a one social worker told us:

> We have to find ways to serve these people as a family unit and not because you're a senior, and you can't make soup for him because he's not a client. The employer, the government has to start looking at family units. How are we going to deliver our services? You know because you have families with needs. I have families with 3 adults and 2 seniors. That means 5 clients in the same family. When you have a parent, he's not going to say he can't look after his adult any longer. (SW4, FGA)

10.2.2 Human Resources

The social workers who participated in the focus groups argued that there is a shortage of human resources which in turn results in a slowing of the system. In their words:

> What we have right now, with our financial we normally would have three people doing financials and all summer we've been down to one and a half. So on average it's taking about three months to get a financial done. So you have someone who's brand new and it sits. And then as soon as it goes over

> to the needs assessor they're getting calls from the family saying: 'how come It's been this long?'…. (SW9, FB B)
>
> See with us we have our, they get done relatively quickly but they are doing housing and a number of different programs, they might do long term care one day a week, but it does get done (SW7, FGB)

Other human resources that are lacking, according to the social workers we spoke with, are home support workers, particularly in rural New Brunswick. In the words of one social worker:

> We just need more resources and I don't know if we're going to get more even resources as far as homemakers are concerned, and we need more and more nursing home beds, more and more special care home beds, more special care home beds. (SW 7, FGB)

10.3 Disconnect With Other Services

Another systematic issue the social workers we spoke with raised is what they understood as "a disconnect" (SW11, FGB) between the LTC program and doctors working with seniors within the health care system. Specifically, they said there was a lack of knowledge on the part of these doctors as to what home support services a senior could reasonably expect to receive. In their words:

> I think the problem with that is the message is not getting out clearly. Sometimes the message from the hospital and the doctor's office is we can offer whatever you want (SW5, FGB)
>
> ….[They say:] 'You need 24-hour care, just call Social Development and they'll give you someone to stay with your mother for 24 hours a day.' Or 'if you need someone to do housekeeping, call Social Development and they'll do that for you.' And I've gone to homes many times and have a note from the doctor that says: 'so and so needs help with this, this, this and this' and it's all nothing that is medically [eligible], or that's going to affect her daily living…. (SW10, FGB)
>
> … I find sometimes when it's related to the hospital especially is that we've told them before that we don't provide that, but I think they think if they keep

> pushing it…. that something will change, and it's like: 'I'm sorry! I couldn't give you 14 hours yesterday, I can't give you 14 hours today, if you call me tomorrow I can't give you 14 hours a day.' (SW9, FGB)

Moreover, these social workers linked this disconnect to the pressure health care providers are under to release seniors from hospital. The problem these social workers say is that seniors are released before home support services can be set up, leading to readmissions. In their words:

> And that's why the clients keep coming back to the hospital for return visits…. (SW6, FGB)

> …. And that's a whole new set of problems, that we're seeing people that are released from hospital with no case plans. (SW7, FGB)

Also at issue for these social workers is the disconnect they saw between home support and extra mural services. They put it this way:

> Another big thing is they get released with four weeks of interim services from Extra Mural, like Extra Mural puts that program in. But after, the Extra Mural doesn't have to look at financials and we do. So by the time those 4 weeks are up and we've been out to do the assessment we find out they're not eligible because of their financial information, so the hospital releases them on that condition [but]….(SW5, FGB)

10.4 Discussion

The social workers who participated in our focus groups expressed the view that the underfunding and lack of resources they experience in their work, as well as the disconnect between their program and other programs and departments, reflect that long term care for seniors is not among the top priorities in the provincial social safety net, and is a program valued below extra mural health care as well as adult and child protection services. In the words of one social worker:

> And it might be a whole system problem. Long Term Care is not a mandated program, so a lot of the resources, if they need them, are going into adult protection and child protection. …. But Long Term Care's kind of on the bottom. It's like: 'okay, we'll worry about the problems there last.' (SW6, FGB)

11. Recommendations

1. Invest in home support as a cost effective alternative to nursing home care.

Supporting seniors in the home is more cost effective than nursing home care except in the case of seniors with serious illness or disability, even when the cost of support workers is calculated at replacement cost (CHA 2009; Chappell et al. 2004; CIHI 2007; Forbes and Janzen 2004; Hollander and Chappell 2002; Hollander et al. 2007, 2009a, b; Shapiro and Havens 2000; VON 2008).

2. Ensure continuity of home support workers over time.

The seniors who took part in this research told us they find it difficult to adjust to frequent changes in homemakers and that this issue is even more acute when it concerns personal care workers. Continuity of care is a key factor impacting on seniors' experiences of home support (Aronson 2003, Sharman et al. 2008). Moreover, positive relationships with their home support workers that involve emotional care are highly valued by seniors and have a positive impact on their wellbeing and quality of life (Francis and Netten 2004, Gantert et al. 2008, McWilliam et al. 2003). Such relationships are only possible with continuity of home support workers over time.

3. Require different and appropriate levels of skills training for homemakers and personal care workers.

According to Madeline, one of the seniors who took part in this research, "not every one" can be a home support worker, and being a good home support worker

requires skills training. However, not all support workers need the same level of training. Almost all (89%) of the 4289 seniors who are provided home support via New Brunswick's Long term care program receive home making and/or housekeeping services and less than 2% receive personal care services (Mather et al 2011). Thus while some home support workers need training in personal care, the vast majority need to acquire homemaking skills.

4. Support investment in accessible transportation for seniors.

The lack of transportation for seniors emerges as a central problem in their ability to remain independent (Smith and Sylvestre 2001, Turcotte 2006). Recently a new type of wheelchair accessible vehicle toured in New Brunswick that accommodates two wheelchairs and is designed such that passengers face forward as do passengers do in cars and vans not modified for wheelchair use (CBC 2011b). The cost of these vehicles is far less than the cost of larger mobility vans and buses. Moreover, smaller vehicles mean more convenience for clients as such vehicles can make more frequent journeys. As important, there would be less waste per trip as there is when large vans carry only one passenger. We recommend that the Department of Social Development support the purchase of such vehicles for public and private mobility transit in New Brunswick.

5. Support a variety of housing options for seniors who receive home support.

Seniors overwhelmingly want to live independently in their communities and all those we spoke to had no desire to entre a nursing home (CHA 2009, CHCA 2008b, HCC 2008, McCann et al 2005, Sanders et al. 2005). Seniors need a variety of housing

options in which they can receive home support services (Shiner et al. 2010). In addition to their original homes, apartments, retirement communities, and assisted living facilities, we recommend that the Department of Social Development invest in research on foster families to determine their potential as a partial solution to situations where seniors have no family but want to remain living in their communities and need more care. Further we recommend that the Department consider making use of special care homes, which have the potential to be more home like, as a cost effective alternative to nursing homes (Chilibeack 2011). Finally, we recommend that the Department support changes to the building code to ensure that all new housing is appropriate to aging in place. For example, new housing should include wide hall ways to accommodate wheelchairs and bedrooms situated on the ground floor (Shiner et al. 2010). Such universal housing design benefits all in society.

6. Replace menu driven assessment with needs based, client-centred assessment.

Rather than menu driven assessment, provide case managers with a budget that allows them flexibility in coordinating an array of services that better address the unique needs of the seniors they work with and allows for creative case management. In this way the assessment process becomes more client centred and is based on “what is possible, not what is [merely] available” (Davis et al. 2005:125). In better matching services to needs, assessments become more rational and efficient.

7. Re-couple assessment and case management duties.

The social workers who took part in this research explained that separating case management and assessment duties resulted in a number of problems, many with cost implications for the Long Term Care system. These include: confusion for both clients and case managers; unnecessary delays; loss of information; and duplication of work. Having the case manager also conduct the assessment would address these issues as seniors would have one person to contact, case managers would be more familiar with the clients that make up their caseload, work would not be duplicated, and there would be less potential for loss of information.

8. Support Social Workers so they are able to conduct biannual follow-up with clients.

The caseloads that many case managers currently carry preclude regular follow-up with clients. We recommend that the Department initiate discussions to explore how to best support case managers in conducting biannual follow-up with the seniors who are their clients.

9. Allow hiring of family members to provide home support.

Under appropriate circumstances, and coupled with robust accountability procedures, allow family members to be hired to provide home support in order to address the lack of home support workers, especially in rural areas, as well as to address issues of continuity of care and quality of services (Matthias and Benjamin 2003, 2008).

10. Evaluate the financial assessment procedure to ensure equity of client contributions.

To better distribute what are scarce resources, evaluate the financial assessment procedure to ensure that those seniors most in financial need pay the lowest client contribution for their home support services.

11. Work toward better co-ordination between the Long Term Care program and other overlapping programs and services.

Provide workshops to inform staff of overlapping services and programs, such as those working in extra mural health care services, and physicians working in provincial hospitals, to increase their awareness of the services available to seniors via the Long term care program.

12. References

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